			1- State of Maryland / Department / Department / Department / Department / Department / Departme	irtment of Health and N <i>tificate of Death</i>	lental Hygien Reg. N		21501
I	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Ruth G. Coleman		2. Date of Death Month June 30,2	2008 Year	3. Time of Death 4:45 AM
	Examin		4a. Facility Name (If not institution, give street and number) 4657 Dallas Place #101	4b. City, Town, or Location of Death Temple Hills	1	c. County of Death	
Ī	Funeral Director		5. Social Security Number 578-84-1652 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 19 September		nplace (State or Foreign untry) inia
	and w.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. fnside City Limits
	Maryl B-1 sho	tor	Maryland Prince George's Temple Hi	.11s			Y Yes 2 No
	th with the 23a or 28 set be not	Funeral Director	10e. Street and Number 4657 Dallas Place Apt 101	10f. Zip Code 20748		citizen of What Col ted State	
036	be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show avent, the Medical Exortical rotat be notified at	by	1 Never Married 2 Married 1 Yes 2 1 No	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	a, etc.
Maryland 21215-0036	should be filed within 72 ho nd Mental Hygiene. s marked other than "natu umatic avent, the Medical	Completed	(Specify only highest grade completed) (Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired) r Worked — None	ing	Kind of Business/I	Industry
nd	al Hyg al Other vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide	en Sumame)	
<u>S</u>		70	Jesse James Coleman Sr		s E. Wiggi		
_				g Address (Street and Number or Rur 6 Horseshoe Rd, C			(ip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other tra pncg.		20a. Method of Disposition 1 Series 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crem	sition (Name of natory or other place) July	Date 20c.	Location - City or	Town, State
Ē	it. Pag rtment rtant; njury c		'4 □Donation 5 □Other (Specify) Ebenezer	Cemetery 200: Name and Address of FacilityRobe		ggum, Vi	
B	Depa impo any i	U		61 Good Hope Rd S			
Ţ			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
ă.	Physician /Medical		resulting in death)	n cinoma			Onset and Death
	Examiner		Due to (or as a consequence of):				
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
60,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):	•			
68/60	ificate g physi as the	edicai	d				
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of deli Month	ivery Day Year
S,	w requires that the de been signed by the should be detached	by Ph	Part If, Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Hecords,	requir		Muleston		1 Tes		
		Completed			24a. Was an autopsy performed?	death?	topsy findings available completion of cause of 2 no
Vital	ysiclan: is certific director,	o Be	25. Was case referred to medical examiner? Hospitaf: Description Company Compan	Other	h (Check only one)	C [] () () ()	-7.1
סר	ig Phy ter this neral d	-	1 Yes 2 No 100 No 1 Injury 28a. Date of Injury (Month, Day Year) 1 Natural 5 Panding (Month, Day Year)	1 3 DOA 4 Nursing Ho	28d. Describe how in		city)
DIVISION	ttendir death. tor: Af the fu	catic	2 Accident investigation	M 1 Yes 2 No	28f. Location (Street	and Number or D	Toute Number
2	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Atter this certifical completely filled in by the funeral director,	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	110)	
	e Hosp 24 hole Fune letely fi	ledicai	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, deatly and manner stated. 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
	To the vithing To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Monti	h, Day, Year)
	1		30. Name and address of person who completed cause of death (ftem 23a), (Type,	943216	J	uly 2	1 2008
_			764 S. OSBORNE &F 106	"Cyper, MANL	Bond 11	9 207	721
	Sta Registr		31. Date filed (Month, Day, Year) 32. Signature 33. Date filed (Month, Day, Year)	rack)			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month **Physician** 2:40 PM Edwin Cauley , 2008 un /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1951 |
Months Days Hours Min. | Min. | August 19, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days 1 **X** M 2 □ F 56 578-74-4525 Washington DC Director Usual Residence of Decedent 10b. County 10a State 10c City Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating and the collined at once. Director 1∏Yes 2∏No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 Redditch Court 20774 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 Black 1 Tyes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twe1ve Space Craft Assistant Allied Signal None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Cauley Christine Flournoy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Cauley/Wife 1304 Redditch Court, Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) July Date 1. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cem 2008 Silver Spring MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert G Mason Funeral Home Inc 1661 Good Hope Rd SE, Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examine if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed DISEASE attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sign be icate has been si, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a Was an autopsy performe certificate 2 **(4No** Division of Vital 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DN 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite#10-A Grenbel Cec: 1500 Tanover Gorde 31. Date filed (Month, Day, Year) State 03 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21503 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year FRANCIS E. CARLIN, III JUNE 2008 4:55 P. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 68 ACORN CIRCLE APT. 202 TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ★ M 2 □ F 212-42-0872 3/19/1945 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 ☐ Yes 2 ☑ No TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 68 Acorn Circle Apt. 202 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No IfYes, Give Year or Dates:VIETNAM 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√∑ No Specify 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) UNAVAILABLE UNAVAILABLE 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS E. CARLIN SUSAN MCKAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ORLANDO, ROBERT CARLIN/BROTHER 9216 JARVI COURT 32817 FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 7/1/2008 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON. 23a Part Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): pentens Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last pidem HyperLife
Due to (fir as a consequence of): yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 **X**No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \hat{\text{M}} Residence 6 \subseteq Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /Medical Examiner

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Hospital or Attending Physician: The law requires that the death certificate be executed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, If I Medical Examples must be notified at

Maryland 21215-0036

Baltimore,

Examine burial-trar Physician/Medical the as

Completed by

Be

Certification: To

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner' 1 Yes 2 No

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

6 ☐ Could not be

determined

MD

29c. License number D 2681

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barthe 31. Date filed (Month, Day, Year)

03

32. Registrar's Signature

Registrar

10 N.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day

JUNE

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	Physici /Medic Examir	cai	1 - For State Registrar 1. Decedent's DIANE 4a. Facility Nar Baltic
	Funeral Director		5. Social Secu
८ರ ಟ್ರಾರ್ಡ್ಸ್ 121 <i>an</i> ಲ timore, Maryland 21215-0036	in 72 hours after death with the Maryland I "natural", or Items 23a or 28a-f show ledical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residen 10a. State Mary1ai 10e. Street and 8006 11. Marital State 1 □ Never 3 □ Widow Elementary/ 10 17. Father's No
しのいのと Itimore, Man	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Impopartment if item 27 is marked other than any Injury or other traumatic event, the Monee.		19a. Informan E1don 20a. Method o 1 X Burial 4 □ Donat
Bal	Depa Impo any I		

3. 2008 4c. County of Death cility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Itimore Washington Medical Center 6len Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) al Security Number 7. Age (In yrs. last birthday) Days Months 1 □ M 2 👿 F 15 40 4652 04/15/1942 Residence of Decedent 10c. City, Town or Location 10b. County Anne Arundel Pasadena yland treet and Number 10g. Citizen of What Country? 10f. Zip Code 8006 Cuba Drive 21122 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) rital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nentary/Secondary (0-12) College (1-4or 5+) Homemaker 10th Own Home 18. Mother's Name (First, Middle, Maiden Surname) ther's Name (First, Middle, Last) Lawrence Giffiths Margaret Ellis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eldon Cowger / Husband 8006 Cuba Drive Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 07/02/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Lice 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death)

Physician /Medical Examiner

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

COPD (CHRADIC OBSTOUCTIVE PULHAUMAN DISEASE) EXACENSATION ~2 DAYS Due to (or as a consequence of): ~304EARS SMOKING Due to (or as a consequence or) Due to (or as a consequence of)

Examine Physician/Medical þ Completed Be ဥ Certification:

IF FEMALE:	
23b. Was decedent pregnant	
in the past 12 months?	
1 ☐ Yes 2 No	
9 🗆 Unknown	

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

3c.	If yes, outcome pf pregnancy
	1 ☐ Live birth 2 ☐ Fetal death
	4☐Pregnant at time of death
	9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COWGER

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a Was an

Year

10:57 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 🛣 No

Maryland

White

1☐ Yes 2 No 26. Place of Death | Check only one 1 Nnpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Hospital:

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Discours you aim pres

5 Pending

investigation

6 Could not be determined

29c. License number D0065314

20HE 58 5008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUILLERMO JOSE GIANGRECO 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161-5803 31. Date filed (Month, Day, Year)

Registrar

Medical



DHMH 17 Rev 1/2001

in 24 hour. the Funeral Dire

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Jur.e 16, 1:27 PM M 2008 Herbert L. Crawford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 633 N. Aisquith Street Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 28, 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1♥ M 2□ F Yrs 70 240-54-2521 1938 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow 10b. County r than "natural", or Itema 23e or 28a-f ahov the Medical Examiner must be notified at ty⊡Yes 2 □ No MD Director Baltimore 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 633 N. Aisquith Street 21202 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 laborer construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental Thomas Crawford Susie Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Crawford/spouse 545 Chateau Avenue Baltimore, MD 21212 Health item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of H important: If Its any injury or of once. 1 Burial 2 Gremation 3 Removal from State 4 □ Donation 5 🖔 Other (Specify) in state 21. Signature of Funeral Survice Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** Discare yeary /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Use to (or as a consequence of): Examine or Attending Physician: The law requires that the daath certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Qnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral C completely filled To the Hospital 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Than Poon, mi) 057088 JUNE 20, 2008. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

301

0 3 2008

31. Date filed (Month, Day, Year)

82. Registrar's Signature

Baltimore, m) 2/242

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Month June 5:00 a /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7907 Ardmore Ave. Baltimore Parkville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29,1940 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 F Months Hours Maryland Director 216-38-6296 68 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Midlical Examiner must be notified at Director 1 ☐ Yes 27 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7907 Ardmore Ave. 21234 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Examine Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ 3 ☐ Widowed 4 ✗ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Sinai Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Wible Virginia Mc Gill 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie M. Caprio / Daughter 7907 Ardmore Ave. Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7-1-08 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licens 23a. Part 1. Enter the discusse of emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 310n Cance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Dav 1 Yes 2 No 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗷 No To the Hospital or Attending run continued within 24 hours after death.

To the Funeral Director: After this certifical continued in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Mary	iano / Depa <i>Cei</i>	artment of F rtificate of I	ieaith and iv Death	лептат нуд в	eg. No. 2008	21507
*	Physicia	-	1. Decedent's Name (First, Middle, La GENEVIEVE E. CA)	,				2. Date of Deat Month JULY	Day Year 1, 2008	3. Time of Death 5:05/9M
) }	/Medic Examin	les)	4a. Facility Name (If not institution, giv			4b. City, Town, or	r Location of Death		4c. County of Dea	
			GOOD SAMARITAN			BALTIMO		l o Data at Dilla	N/A	
	Funeral Director		215-18-0440	6ex 1 □ M 2 □ XF	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG 17	Year) 9. Bir	thplace (State or Foreign ountry) MD
	ryland how at		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	Director	MD N/A		BALTIMO					1 X Yes 2 No
	with th		10e. Street and Number			10f. Zip Code 21206		1	0g. Citizen of What Co	ountry?
	eath v	Funeral	3714 RASPE AVE	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H		ecify Yes or No-	14. Race - Ame	erican Indian,
136	3 within 72 hours after death with the Maryland jiene. 1 than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	2	1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, Puèrto Specify:	Rićan, etc.)	Black, Whit	e, etc. HITE
15-003		Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most of work	ting	16b. Kind of Business	/Industry
2121	filed within Hygiene. Ither than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	i	EMAKER	- /		OWN HO	ME
	Hyge street	BeC	17. Father's Name (First, Middle, Last				18. Mother's Nam			
<u>X</u>	should be nd Mental marked c	2	STANISLAUS KOCI		10) 14 77			ANDRA MI		7: 0: 4:1
Maryland	32 h a 7 is		19a. Informant's Name/Relationship						r, City or Town, State, MD 21206	Zip Code)
<u>၈</u>	s 1 and of Health item 27 other tr		JOSEPH CARNAGGI 20a. Method of Disposition	2	0b. Place of Dispe	14 RASPE osition (Name of matory or other place	i		20c. Location - City or	Town, State
Ē			1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		GARDENS		7/5/	/08	BALTIMORE	, MD
Baltimore,	permit. Page Department (Important: if any injury or once.		21. Signature Funeral Service Lice	nsee		2. Name and Addre 6415 BELA			PEL FUNERA RE, MD 212	L HOME, INC.
8			3a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the one cause on each line.		_		or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. MYOCA		INFARCT	102			Sudden
	/Medical Examiner			Due to (or as a co		RAENI	DISTEAS	E		Years
+	9 #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):	to A D	=111.0=	50,000	ΕΛΙΙΔ	years
/	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. THYVOVA		MABER	53/ 1141/0	VICIF (D	0000	qcars
98760	ficate be executed physician and sthe burial-transit		(d						
_	tificate ng phy as the	fedical		_ u.						
P.O. Box	the death certificate be executed the attending physician and ched for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnance □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
	ires that the de signed by the a be detached f	by Ph	Part II. Other significant conditions		-	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rg	w require been sig should be		ADENOLARE	UNOMA G	OLON	1999		1 □ Y	es 2XNo 3□F	Probably 4 □Unknown
Vital Records,	sician: The law requires that the certificate has been signed by th rector, page 2 should be detache	Completed						24a. Was a autops perfor 1∐ Yes	sy prior to	utopsy findings available completion of cause of
/Ita	cian: ertifica ector, I	Be C	25. Was case referred to medical examiner?			4 011	26. Place of Deat			
	Physic this c	2	1 ☐ Yes 25 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		4 □ Nursing H		ence 6 ☐Other (Spe	ecify)
o	iding F h. After funera	tion:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye		Woi	rk? Yes 2∐No	zou. Describe n	ow injury occurred	
Division or	il or Atter after deal I Director d in by the	Certification:	3 Suicide 6 Could not be determined	De Place of injune	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C		hysician: To the best of mainer: On the basis of exa and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	_ MD		29c. Licens	se number	2	29d. Date signed (Mon	th, Day, Year)
,	O		30. Name and address of person who	KUEGMAN	1505	OSUER	DR T	DUSON	MD 2120)Y
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	and a				•

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 21508 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** WILLIAM DAVIS 6:57PM June 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore N/A NES Hospital 8. Date of Birth (Month, Day, May 14, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ^{Year)} 1930 217-24-1691 1**X** M 2□ F 78 Months Days Hours Min. May Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other than "natura", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 32 Maple Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Keyes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin. Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 Is marked 1 any Injury or other traumatic eventage. Edward J. Davis Margaret Chearei ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grimes Tina (Niece) 1633 Colony Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 06-21-08 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Furreral Service Licenses 3204 Mountain Road, Pasadena, Maryland 21122 23 yart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Acute Intracranial Hemorrheuge nouvs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WEEK Supdural Hematoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CERTIFICATION APPROVED BY MEDICAL EXEMINER Examiner Due to (or as a consequence of) law requires that the death certificate be executed the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Ye aı Month Day 5 Other (specify) o as been signed by the 2 should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, Dertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy The performed Vital 2 100 1 Tyes 2 1 🗆 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 H Certification: To After this Division of 28a. Date of Injury
(Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 CHatural 5 Pending investigation Probable fall. **Unknown**M 1 □ Yes 2 📉 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Bural Route Number, City or Town, State) Found: 32 Maple Avenue, Catonsville, MD determined 4 Homicide Found: Home To the Hospital hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17,2008

Registrar
DHMH 17 Rev 1/2001

State

900 caton Avenue Baltimore

30. Name and odress of person who completed cause of death (Item 23a) (Type, Print)

Paul

31. Date filed (Month, Day, Year)

1)2(

astro

Registrar's Signat

Physician
/Medical
Examine

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If w Medical Examinant be nealfied at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed use as the burial-tran P.O. Box 68760, cate has been signed by the page 2 should be detached After

of Vital Records, Division ours after death, neral Director: A filled in by the fu To the Hospital o within 24 hours af To the Funeral Di completely

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28 H4 Year Month Doricent Tram 820p M Pierre JMO 2008 4a. Facility Name (If not institution, give street and number eason sons 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Northwest Hospitalat Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
01 23 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F Days Hours 016-80-3957 Haiti 93 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 No Director Malden MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 02148 Haiti 9 Benner Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ※☐ No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ∏Yes 2XINo Haitian Completed by Specify: 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 10th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ifosia Hyppolite Regules Doricent ၉ 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)
121 Kennedy Drive, Malden, MA 02148 19a. Informant's Name/Relationship (Type. Print) Joseph Doricent-Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/5/08 Malden, MA Holy Cross 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1 Enter the disease, or complications that cause to e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) SCASONS Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 M Naturai 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number JMG 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTOLSTOWN MP Deperah Plance 25 MAIN STILL 31. Date filed (Month, Day, Year) Registrar's Signature State 03 Registrar 2008

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Leonard Dubrow June 5:12 pM 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Prince George Laurel 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 84 Director 144-14-2148 N.T Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Prince George Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or Items 23a or Medical Examiner must be r 8806 Orwood Lane 20708 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1942-67 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Air Force 5 Military Officer other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be 9 Department of Health and Mental Important: If item 27 is marked o Herman Dubrow Sadie Gleeck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Miriam Michie Dubrow/ Wife 8806 Orwood Lane, Laurel, MD 20708 Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 22, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cem. 2008 Arlington, VA 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Ken Skils M01053 313 Talbott Ave., Laurel, MD 20707 23a. Patri Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebral Hemorrhage /Medical Due to (or as a consequence of): **Examiner** Cerebrovascular Accident Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed Aortic Stenosis 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 2 No 1∐ Yes 2/2 No To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1X Natural 2 Accident 1 ☐ Yes 2 ☐ No in 24 hour.

the Funeral Directory filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide *Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpletely (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20064986 7/1/2008 30X1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chike Onwuka, MD 10724 Little Patuxent Parkway, Suite 200, Columbia, MD 21044

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 11:24 A 0120 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1 № M 2 🗆 F 213-28-8793 76 Yrs. 26,1931 Maryland Dec. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Director Ft. Howard Maryland Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21052 United States Funeral 9123 Todd Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 25 Married 1 ☐ Yes 2 ☑ No Specify δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pipefitter Construction 6 Years 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie C. Morrison Josef J. Dillian ည Wife 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ft. Howard, Maryland Mrs. Margaret Mary Dillian 9123 Todd Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/3/2008 Marriottsville, MD Crest Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a conjequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) a Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? Day Year Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA **✓**Inpatient ၉ 27. Mariner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Pending investigation Injury 1 Tyes 28f. Location (Street and Number or Rural Route Number, City or Town, State)

attending physician and d for use as the burial-transit The law requires that the death certificate be executed Box 68760, be detached for P.0. the ģ of Vital Records, this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Division

Baltimore, Maryland 21215-0036

Certification:

Medical

6 Could not be determined 3 Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and mainten as dause(s) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1000 65652

thangara

29d. Date signed (Month, Day, Year) time 29,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins M. Mede exterance

31. Date filed (Month, Day, Year)

0

3 2008

29b. Signature and title of certifier

29a. Certifier

(check only

32. Registrar's Signature

NID

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:45P DENISE DORSEY 25, 2008 ROXANNE JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/2/4967 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Days Hours 219-78-8617 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Yes 2 No Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 USA Dulaney Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) are Giver 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peggy Bowens Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorsey Jonas Frederick, MD 21702 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Cemetery Voly 2008 21. Signature of Funeral Service License 22. Name and Address of Facility 110 West South Street Gary L. Rollins Funeral Home Frederick, MD 21705 \propto 23a. Part. Enter the dis-rise, or commendations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician enc HNOXIZ /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed probable Box 68760% Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5706 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hee 70C U 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

3 2008

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3altimore.

or Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 06 29 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical NIA if Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Pate of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 3/3 212-32-6 DECEMBER 4,1931 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at NA 1 Yes 2 □ No Director BALTIMORE MARYLAND CITY Pages 1 and 2 should be filed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 400 MILLINGTON AVE., APT. 229 U.S Q1QQ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BUACK 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CO. 8TH GRADE CONSTRUCTION WORKER permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if Item 27 is marked other ti any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EVERETT FCK MILDRED JOSEPH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 757 W. HILLS PKWY, BALTIMORE, MD 21229 (NEPHEW) BRYAN HOLLEY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEMURIAL PARK 07-07-2008 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MIDSISIT elliano 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician Fai Heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Poxia that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown has been signed le 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I Director: After t d in by the funera 28c. Injury at Work? Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated.

Division or Vital Records, P.O. Box 68760,

State Registra 29b. Signature and title of certifie

Year)

30. Name and address of 205 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydien 2008

			1 - For State Registrar	State of Maryland	Department of Certificate of		vientai Hygien Reg. N	
	Physici		1. Decedent's Name (First, Middle, Las	for Ealy			2. Date of Death Month D	Day 7 2008 1550 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town,	or Location of Death	V	ic. County of Death
	Funeral Director		5. Social Security Number 6. So	7. Age (In yrs. Is	ast birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) All Mary land
	σ		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location	11.		10d. Inside City Limits
	the Many 28a-f ah	Director	Mayland NI 10e. Street and Number	H _	Bay 10f. Zip Code	Himore	100 0	1 Pes 2 No
	death with the Maryland ims 23a or 28a-f show ritust to indiffed at	ral Dir	799/2 N. Ora	nttey St.		21229		USA
9036	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examiner must be notified at ADEs.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 You If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu		pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	filed within 72 hours after Hygiene. kther then "natural", or Ita ktt. tre Medical Examira	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occi (Give kind of work don life. DO NOT use retir	e during most of wor	kina	Kind of Business/Industry DNS+Mc+toN
and 2	ld be filed ental Hygi kad other ic avant, I	To Be Co	17. Father's Name (First, Middle, Last)		00/10/1	18. Mother's Nan	ne (First, Middle, Maide	
Mary	and 2 should ealth and Men n 27 is marks her traumatic		19a. Informant's Name/Relationship (7	ypo, Print) SISTEY		et and Number or Ru Hown G	ral Route Number, City	v or Town, State, Zip Code)
Baltimore,	Pages 1 aunent of Heannt: If Itam		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	ace of Disposition (Name of impetery, crematory or other place), Clina		Date 20c.	Location - City or Town, State
Balt	permit. Departr Import		21. Signature of Funeral Service Licenter	Parker	22. Name and Add 3572 Frey	ress of Pacility Pa denick A	Kerture R. Baltin	ore, Maryland 21829
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the death one cause on each line.	. Do not enter the mode of dy	ring, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or as a consequ	ence of):	Deficience	cy Syndr	ame
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or as a consequ	ence of):	201101011	9 991 11.01	
68760,	ifficate be executed g physiclan and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a consequent	ence of):			
Вох 68	eath certifica attending phi for use as th	In/Medi	230. was decedent pregnant	23c. If yes, outcome of pregnar		ion.		23d. Date of delivery
o	t the deat by the att ached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de				Month Day Year
rds, P.	The law requires that the death cert lite has been signed by the attendin page 2 should be detached for use	Ď	Part II. Other significant conditions co	ontributing to death but not resu	lting in the underlying cause g	jiven in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 🖺 No 3 🗒 Probably 4 🖄 Unknown
Reco	he law re e has bee age 2 sho	Completed					24a. Was an autopsy performed?	
<u>ita</u>	ysician: The l is certificate ha director, page	BeC	25. Was case referred to medical examiner?			26. Place of Dea	1 ☐ Yes 2 ☑ Nath (Check only one)	No 1 Yes 2 No
Division of Vital Records,	Attending Physician: ir death. actor: After this certifics by the funeral director, I	၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury W		ome 5 Residence	
Divisi	는 는 ft &	Certification:	3 Suicide 6 Could not be determined		me, farm, street, factory, office		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physical Authors Authors also death. To the Euneral Director: Afler this completely filled in by the funeral directors.	Medical C	29a. Certifier 1 Certifying Phyone) Certifying Phyone 1 Medical Exam	ysician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death occurred at the	time, date and place opinion, death occu	e, and due to the cause erred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	Now Just	29c. Licer	nse number		Date signed (Month, Day, Year)
	1		30 Name and address of person who co	completed cause of death (Item	23a) (Type, Print) GCr.	reral H	ospital	
1	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure foots			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Linda Marie Edwards JULY 2008 Ø1:25AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Tawsan Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/06/1941 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Maryland 1 □ M 35 F Director 216-40-2344 Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show Baltimore Maryland 1¥¥Yes 2 □ No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Wedfeel Examiner must be no once. 919 Armistead Way 21205 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Completed by Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Strange Hall Martha Pauline Harman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1923 Wilson Point Road, Baltimore, Maryland 21220 Betty Clevenger (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State Hall Family Cemetery 07/05/2008 Walkersville, W. Va. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Bruzdziński Funeral Home, P.A 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by CEREBRO VASCULAR ACCIDENT 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE HEART FAILURE 24a. Was an cate has I page 2 s this certificate 1 ⊡Yes 2 XV0 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

D

Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

JUL 0 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601

32. Registrar's Signature

29c. License number

D37254

OSLER DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 24a per verb., g881,07,08,086bbh Reg. No. 2008 1 - State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yea 9:07 D M Farino Millie 06 2008 3 4c. County of Death 4b. City, Town, or Location of Death

Months

1 ☐ Yes 2 No

Baltimore

Days

If Under 1 Year | If Under 24 Hrs.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

Physician
/Medical
Examiner

4a. Facility Name (If not institution, give street and number)

10b. County

tvoca

1 Never Married 2 Married

3 Widowed 4 □ Divorced

6 Sex

Howar

1 □ M 2 N F

venue

University of

5. Social Security Number 188-07-9552

Usual Residence of Decedent

10e. Street and Number

11. Marital Status

10a. State

MD

Funeral Director

28a-f show ns 23a or 28a-f shov must be notified at or items "natural" traumatic event, the Medical

Funeral Director

þ

Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meone.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed Division or Vital Records. P.O. Box 68760. signed by to d be detach To the Hospital or Attending Physician: After this 24 hours after death. Within 2

Conte

Examine Physician/Medical Completed by Be Certification: To Medical

Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic 6th 17. Father's Name (First, Middle, Last Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, 5122 troca Grubb 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 □ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Fa lity 5151 Batto. Condition of the War 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ristanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) vator Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown coronary artery seres Miser lipidemie autopsy performed? 1 Yes 2 XNo 25. Was case referred to medical examiner? Other: 4 Nursing Hor Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA 1 Pes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☑ No 15/08 12:00 PM 2 Accident 6 Could not be determined 3 Suicide Place o injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home 5122 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

7. Age (In vrs. last birthday)

Yrs.

10c. City, Town or Location

88

USA 14. Race - American Indian, Specify:

10g. Citizen of What Country?

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

16b. Kind of Business/Industry ones

8. Date of Birth (Month, Day,

al Route Number, City or Town, State, Zip Code) Ellicott City, MD 21043 20c. Location - City or Town, State

Baltimore, and

CERTIFICATION APPROVED BY MEDICAL EXCHANCE

tracitures 23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Month

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

26. Place of Death (Check only one)

ne	5 ☐ Re	sidence	6 □Oth	ner (Spe	ecify)			
28d.	Describ	e how inju	ary occur	red				
Pa	tient	strum	bled	and	broke	har	200	المعال
206		10			(O d	- 11	4	

28f. Location (Street and City or Town, State)

Avoca

29d. Date signed (Month, Day, Year) 29c. License number

23 08

30. Name and address of person where dause of death (Item 23a) (Type, Print)

reene

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMNO III-W#I6a, b, perfff, (881, 7/3/8, WS)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year OS Month **Physician** 5:01 PM Irene T. Fotis 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square Baltimore Rosedale rantin HOSDITA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

New York Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2CXF Months Days Hours Min. 067-26-5523 74 03/29 1934 Director New Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ms 23a or 28a-f shor 1 ∐ Yes 2 TXNo Maryland Harford County Bel Air Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with United States 100 A Hazelnut Court 21015 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Yes} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any Injury or other traumatic event, it a Maxical Examinations. Black, White, etc. 1 □ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White ₽ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

TeanPreanancy—Counselor

TeanPreanancy—Counselor 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Counseling Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Schaefer Margaret Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 A Hazelnut Court, Bel Air, Maryland 21015 Mr. James Fotis (Husband) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Fureral Chapel Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/2 2008 Forest Hill, Maryland 22. Name and Address of Facility

Wars Funeral Chapel & Cremation Services - Bel Air 21. Signature of Funeral Service License al 3 Newport Drive, Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical ue to (or as a consequence of): Examiner usal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit signed by the attending physician and be detached for use as the burial-tran The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Cholecystitis Physician/Medical 29 ngrenous 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably W Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce 30. Name and address of person who complete se of death (item 23a) (Type, Print) Eq 9000 Franklin Square Drive Baltimore MD 31. Date filed (Month, Day, Year) legistrar's Signature State 0 3 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEATHERSTONG Month **Physician** 2008 28, JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital BAHIMOR INAI Under 1 Year | If Under 24 Hrs. | 8. Date of Birth onths | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 63 44 592 Director marylows Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 es 2 No BALLHOR MALY MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21215 SAK UPA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. CLEANER Presser 12 to grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MGARS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUBEN FEATHER STONE NUSBANO 20a. Method of Disposition 20b. Place of Disposition (Namof cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of I Important: If Its any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State WOUDERON MAY/ON 4 Donation 5 Other (Specify) 21. Signature of Farmed Service see 5240 Reisterstown Ad a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or hear failure. List only one cause on each line. disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit the death certificate be execu Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an has autopsy certificate or Vital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[**X**/No 1 ☐ Yes 1 🔲 Inpatient 2 KER/Outpatient 3 DOA ဠ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

			For Amend Items 1 - State Registrar	State of Maryl 23a, 25, 27, 2	and / Depa 8a-f per <i>Cer</i>	me 8881	o7/02/0d Death	nio Re	eg. No.	800	21519
	Physicia		1. Decedent's Name (First, Middle, Las Mary Florence	•				2. Date of Death Month May	Day	Year 008	3. Time of Death 8:30 P _M
- Bar	/Medic Examin		4a. Facility Name (If not institution, giv 2220 Westridge Ro			4b. City, Town, or Timon	Location of Death		4c. County	c. County of Death Baltimore	
Ī	Funeral Director		213-03-3030	ex □м 2Å F 7. Age <i>(In</i> 91	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08-24-1	91 6	9. Birthpla Count Mary	ace (State or Foreign ry) and
	rytand thow	,	Usual Residence of Decedent 10a. State 10b. County		:. City, Town or Loc					10	d. Inside City Limits
	e Ma Ba-f s	cto	MD Baltin	nore	Timoni						1 ☐ Yes 2 No
	vith th	i i	10e. Street and Number			10f. Zip Code	002	1	0g. Citizen of	S.A.	ry?
	eath v	Funeral Director	2220 Westridge Ro	12. Was Decedent Ever	in IIS 13 V		093	ecify Yes or No-		ce - America	an Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Eventinal must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cuba ☐ Yes 2 🕱 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Special Special	ick, White, e	hite
21215-0036	"natur	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of work		16b. Kind of E	Business/Ind	ustry
212	filed within Hygiene. other than " ent, the Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ne Maker	"		Ov	n Hom	e
þ	e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last,				18. Mother's Nam				
ylar	should be and Mental marked of umatic ev	으	George T. Kohler	<u> </u>				Vincent			
altimore, Maryland	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (Russell G. Fatzir	iger / Son	2220	Westridg	and Number or Rule Rd., Ti	monium,	MD 21	1093	
nore	Pages 1 nent of H int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	I Bemoval from State 11		sition (Name of natory or other place	orp. 06-0		20c. Location Towsor		wn, State
altir	permit. Page Department Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licer	9			ss of Facility Ruc				me, Inc.
ä	permi Depa Impo any ir		Darbara	Lucie			Road, To	<u>*</u> .)4	
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	er the mode of dyir		or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aOn A	nsequence of):	Heart	failure			_	Jun 12
	Examiner		Convention, list conditions	Polm	nan	Floor	2 (0				tyears,
	ed sit	iner	Sequentially list conditions, it any, leading to finite diatactuse. Enter Underlying Cause (Disease or injury	Date to tories a nor	nnagranue):	re Sin	al mari	16	MAINER		meny
	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):		nel one	OVED BY MEDICA	EXAMINE		years
68760,	rificate be executed ng physician and as the burial-transit	edical		d		-	CERTIFICATION				
	ertifica ling pl e as t	Med	IF FEMALE:	00-16			-				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	y			ate of delive	Day Year
G,	s that gned by	by Ph	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	- 1		e cause of death?
ord	tw requires that s been signed t should be deta	ted I	Vertebral	tractice.				1 🗆 Y	es 2 No	3∏ Prob	ably 4 🗌 Unknown
Division of Vital Records,	The law i cate has b page 2 sh	Completed	R heume foid	Arthritis_				24a. Was a autops perfor, 1 🗆 Yes	sy	. Were auto prior to con death? 1 ☐ Yes	psy findings available inpletion of cause of 2 No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		oth	26. Place of Dea				
of	Phys r this ral dir	.To	1 Yes 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatier	11 3 DOA	4 LI Nursing H	ome 5 Resid			γ)
on	Attending Physician: or death. ector: After this certification by the funeral director, R	ition	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Ye.		P Wor	ḱ? Yes 2 X ΩNo		t fell		
ivis	or Atter after des Director in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (S City or Tow Road, Ti	treet and Num n, State) 2	220 Rug	l Route Number, e stridge
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one) 29a Medical Example (Check only one)	hysician: To the best of miner: On the basis of exa	y knowledge, deat amination and/or in	h occurred at the ti vestigation, in my	me, date and place	, and due to the	cause(s) and	manner as s	stated. the cause(s)
	To the comply	Me	29b. Signature and title of certifier	Aluan S	2110	29c. Licens	se number	5	29d. Date sign	ned (Month,	Day, Year) Day, Year) Day (Year) Day (Year) Day (Year) Day (Year) Day (Year) Day (Year)
	(12)		30. Name and address of person who	completed cause of death	(Item 23a) (Type.	Print)		101117	- 1		a la strance
	19		Latorga Edn	10 ds 40	Kais	e pen	evente	1447	yo-li	Road	UD 21093
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature						
	negisti	en .	JUL 0 2 2500	The same of	17						

State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per me 2881 07/02/08dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 31, **GAYLEN JONES** FOSTER 2008 0530 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ST. MARY'S ST. MARY'S HOSPITAL LEONARDTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F APRIL 7, 1943 TEXAS Director 65 462-68-3385 Usual Residence of Decedent with the Maryland 10c. City, Town or Location a or 28a-f show the notified at 10d. Inside City Limits 10a. State 10b. County 1XYes 2 □ No Director PRINCE GEORGE'S **FORESTVILLE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a c 20747 USA 7201 Mt. Forest Terrace Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates; 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or item Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) namental Hygiene. 127 is marked other than "I ir traumatic event **-Elementary/Secondary (0-12) College (1-4or 5+) State Departmnent Management Analyst 4 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Thelma Lee Johnson Sylvester Jones, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if item 27 any injury or other tra 7201 Mt. Forest Terrace Forestville, MD 20747 Ernest Foster / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 06-09-2008 Lincoln Memorial Suitland, MD 21. Signature of Funeral Service Livensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD C 4308 SUITLAND ROAD SUITLAND, MD Donald R. Gray 23a. Part / Inter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Physician Severe -drees disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Qu I monary andio Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Respiratory certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): CERTIFICATION APPROVED BY Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ☐Yes 2☐No Ö 9□Unknown 9 X Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xes 25 Mo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -31-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 Point Lookout Road Leonardtown, MD 20650 David C. **Allen** 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

Aylen

			For State	State of	of Marylan		rtment of H	lealth and M	lental Hyg	iene	n n g	21521	Į
0			Registrar 1. Decedent's Name (First, Middle	(ant)		Cer	lilicate of t	Jealli	2. Date of Deat		000	3. Time of Death	-
	Physicia	an			0 - 1 /				Month	Day	Year		
	/Medic	7.	4a. Facility Name (If not institution	-	RELL		4h City Town or	Location of Death	_06	3 O 4c. Cour	2008	0850 "	_
) 	Examin	er										0.257	
	Funeral		Washington Adv 5. Social Security Number	entist Ho	7. Age (In yrs.	last birthday)	If Under 1 Year	a Park If Under 24 Hrs.	8. Date of Birth		ontgom 9. Birthp	lace (State or Foreign	
F .	Director		007-26-3328	1 ⊠ M 2□F	84	Yrs.	Months Days	Hours Min.	(Month, Day, 2/16/19	924	Char1	eston, ME	
8.	D .		Usual Residence of Decedent								1.		_
	show	_	10a. State 10b. County			y, Town or Lo					1	0d. Inside City Limits 1 X Yes 2 □ No	
	e Ma Ba-f s	Director		George's	s C	o11ege				- 6			_
	vith th	Ö	10e. Street and Number				10f. Zip Code	.=.	1		of What Cour	try?	
	s 23a	ara	5007 Niagara R		cedent Ever in U.	c 110.1)740	onifu Von or No		J.S.A.	an Indian	_
	item item ner n	Funeral	11. Marital Status 1 □ Never Married 2 □ Marr	Armed F		5.	f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		lack, White,		
36	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G	live		I□Yes 2KINo	Specify:		Spec	cify: W	hite	
ğ	2 hou atura cal E		15. Deceden	t's Education		16a, Deced	lent's Usual Occup	ation		16b. Kind of	Business/Ind		
212	hin 7; s. in "n Medi	ple	(Specify only highe: Elementary/Secondary (0-12)		(1-4or 5+)	life. l	NOT use retired	during most of work i)	ing				
21	d with	Completed		Š-			Teacher				ıcatio	n	_
g	0 = 0 %	Be (17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle, I	Maiden Surn	ame)		
Maryland 21215-0036	2 should be filed w n and Mental Hygie is marked other ti raumatic event, th	Jo	Frank E. Farre						I. Stro				
<u>lar</u>	2 sh and is m raum		19a. Informant's Name/Relations				•	and Number or Rui			vn, State, Zip	Code)	
	1 and 1ealth 9m 27 ther t		Keith Leon Farr	ell, Son	20h F			Ct., Boy			n - City or To	wn State	_
סַ	ages In ite		1 ☑ Burial 2 ☐ Cremation		n State		sition (Name of natory or other plac	1			,		
altimore,	it. Partant		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Ft.		In Cemete . Name and Addre	ery 7/10	/2008		wood,	more Ave.	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		Pr mast	The Col	matt			neral Homo	ο ΤΛ			e, MD 2078	1
	3:		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat							Approximate	Ē
	Physician	e a	Immediate Cause (Final									Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. MRS	o (or as a conseq	uence of):	u a_						_
	Examiner			b. MPS	SA BO	dere	mia						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a conseq		1002-120-2						
Ø	ocutec nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с									
.00	oe exe cian a urial-	Ë	resulting in death) Last	Due to	o (or as a conseq	uence of):							
8	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d									_
9 ×	leath certific attending p	Physician/Me	IF FEMALE:	23c If yes o	utcome pf pregna	ancy				224	Date of dollar		
Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	Ideath 3	Ectopic pregnancy Other (specify)	1			Date of delive Month	Day Year	
o.	ires that the de signed by the a I be detached I	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□Unk			2 - a.o. (-p,) =						
Vital Records, P.O.	that ned b		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to t	he cause of death?	
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ř	The law ite has	mo			1				autops perfor 1∐ Yes	med? 2 2 No	death?	mpletion of cause of 2□ No	
Ta Ta	s Iclan: The certificate har rector, page	Be C	25. Was case referred to medica	1	V			26. Place of Deal		·			
<u>-</u>	Physic this ce	70 E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 14	Inpatient 2□	ER/Outpatier	nt 3□ DOA Oth	er: 4 Nursing He	ome 5 Resid	ence 6 □0	Other (Speci	(y)	
Division or	ng P		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	(8.6 -	e of Injury onth, Day Year)	28b. Time o Injury	Wor		28d. Describe h	ow injury oc	curred		
S	terid leath. tor / the fu	cati	2 ☐ Accident investignment in	not be				Yes 2 □ No	205 Leasting (C	ternat and Alv	mahawaw Dun	of Dougla Number	_
፷	or Attending Physiter death. Director After thin by the funeral of	Certification:	4 ☐ Homicide determ	singed ZOU. Fide	ding, etc. (Specil	y)	eet, factory, office		City or Tow	n, State)	imber or Hun	al Route Number,	
	spital ours a neral filled		29a. Certifier 1 Certifyii	ng Physician: To th	he best of my kno	wledge, deat	h occurred at the ti	me, date and place	, and due to the o	cause(s) and	I manner as s	stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, p.	edical	(Check only 2 Medical one)	Examiner: On the	basis of examina anner stated.	ation and/or in	vestigation, in my o	opinion, death occu	rred at the time, o	date and plac	ce, and due t	o the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifie		14.0		29c. Licens		2		gned (Month,		
			Salvyasai	hillar,	, M.D			063703			1001	38	
	1641		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type,	Print) 7600	CARCO.	LL AU	2			
	77	A L						my ph	rr, m	グ			
	Sta Registr		31. Date filed (Month, Day, Year)	2008	Hegistrar's Sign	ature Loa	well .						
	nogioti		JOL 0	1	-	-							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21522

iido Garrido		For State		cate of Death		Reg. N	lo	·
Physicia	n/ 1	egistrar . Decedent's Name (First, Middle,Last)		0 11		Date of Death Month Day	y Year	3. Time of Death 1256 hrs
ি " al Examin		Elfido Amilo		Garrido	or Location of Death	June 24, 2008	4c. County of Dea	
	4	 Facility Name (if not institution, give street and num RT. #495 & 95 	iber)	College Pa			Prince Georg	i i
Funeral			. Age (In yrs. last I	birthday) If Under 1 Ye			M/DD/YYYY) 9. B	irthplace (State or
Director	5	21 19 0414 219-86-8761 1X _M 2 F	56	Yrs. Months Da	ays Hours Min.	10/21/1	951 Fore	Country) Guatemala
any	_ h	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	-	Maryland Anne Arundel	Pasad	ena				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Φl	0e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
th the Maryland 23a or 28a-f sho notified at once.		133 Halifax Harbour		211:		if. Ves er Ne	U.S.A	erican Indian, Black,
th with	unera	11. Marital Status 1 Never Married 2 X Married Armed Fo	edent Ever in U.S.	13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	White, etc.	
er dea	ഥ	1 Yes 3 Widowed 4 Divorced If Yes, Give Year	2 X No	1 X Yes 2	No specify: Gua	temalan	Specify: Spa	anic-White
urs afi	ap Ap	15. Decedent's Education (Specify only highest grad		Sa. Decedent's Usual Occup during most of working I	pation (Give kind of v		b. Kind of Busines	s/Industry
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natura"; or items 23a or 28a-f shommatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1 12 2	4 or 5+)	Maintenanc			dopt A H	ighway
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other tranmatic event, the Medica.		17. Father's Name (First, Middle, Last)	-	. 1		e (First, Middle, Maid		1 -
121 i be fil ental I arked	å	Benjamin Lisand		19b. Mailing Address (St	Catali:			revalo ate. Zip Code)
MD 2 d 2 should lith and M m 27 is m aumatic	٩	19a. Informant's Name/Relationship (Type, Print) Mayra L. Garrido (Wife)		1133 Halifa				1
imore, MD 2 Pages 1 and 2 shou ment of Health and I sant: If item 27 is n or other traumatic	t	20a. Method of Disposition		ice of Disposition (Name of matory or other place)			0c. Location - City	
nord		1 A Burial 2 Cremation 3 Removal fr		r Hill Cemet	ery 06/	28/2008	Brook1yn	, Maryland
Baltimore, permit. Pages I an Department of He Important: If ite	-	4 Donation 5 Other Specify: 21. Signature of Fineral Service Licensee		22. Name and Addr MCCully-P 3204 Moun	ess of Facility	uneral Ho	me. P.A.	
E P E		At fline		3204 Moun	tain Road	Pasadena	. Maryla	nd 21122 Approximate Interval
Physician Medical		23a. Part. Enter the disease, or complications that c follure. List only one cause on each line.		o not enter the mode of dyl	ng, such as cardiac	or respiratory arrest	, shook, or hour	Between Onset and Death
_xaminer	1	Immediate Cause (Final disease or condition resulting in death) a. Multiple Inj	uries consequence of):					
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	je l	Sequentially list conditions, if any, leading to immediate Cause Enter Underlying Cause	consequence of):					
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760, ficate be g physicals the buri	/Me	23b. Was decedent pregnant in the	outcome of pregna	ancy Fetal death	3 Ectopic pregi	nancy	23d. Date of deli Month	Day Year
Box 687 e death certific the attending p ed for use as th	sician/	past 12 months?	ant at time of deat	_				
Box 687	Phys	Yes 2 No 9 Unknown 9 Unkn		ultima in the underlying cau	re given in Part I	23e. Did tob	acco use contribut	e to the cause of death?
P.O.	by F	Part II. Other significant conditions contributing t	o death but not res	diting in the bilderlying cad	iso given in r are i			Probably 4 Unknown
ords, F w requires s been sign should be	ted					24a. Was ar	24b. Wer	re autopsy findings available r to completion of cause of
COFC law re has be	Completed					autopsy perform	ned? dear	
tal Rection: The certificate ector, page		25. Was case referred to medical		26.F	Place of Death (Chec		100	160 2 10
Vital Rec hysician: The l this certificate I	o Be	examiner? 1 Ves 2 No	Inpatient 2 E	ER/Outpatient 3 DOA	Other Nur	sing Home 5 R	tesidence 6 🗸	Other: Scene
of \officers	n: T o	27. Manner of Death 28a. Date			Injury at Work?	28d. Describe ho Eiected Drive	ow injury occurred er auto auto co	ollision
ion tendir eath. tor: A	atio	Prending			X Yes 2 No	1		or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be 28e. Pla		me, farm, street, factory, off	ice building, etc.	28f. Location (St or Town, Sta Rt #495 & 95	reet and Number t ate) College Park, M	MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Cer	29a Certifier	Interstate/E	o death occurred at the tim	ne date and place, a	nd due to the cause	(s) and manner as	s stated.
the Ho hin 24 the Fu	Medical	one) 2 Medical Examiner: On the basis	of examination an	d/or investigation, in my op	inion, death occurre	d at the time, date a	nd place, and due	to the cause(s)
To To COUT	Mec	29b. Signature and title of certifier	stated.		cense number		29d. Date signed	(Month, Day, Year)
		/ /// (_		C	C.M.E.		June 25, 200	08
OCME		30. Name and address of rson who completed car	se of death (Item	23a)		MD 04004		STORES STORES
OUNE		Mary G. Ripple/MD. Deputy Chief	Medical Exam	niner 111 Penn St	reet, Baltimore,	IVID 21201		
S Reais	tate	26 26 61 43 2 111123 1 2732	egistrar s Signe	Smile				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008 1 - State Registrar 21523 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 Month **Physician** Harry Goble June 28 4:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4801 Ruby Avenue Halethorpe Baltimore 5. Social Security Number Sex 1M M 2□ F 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min. Months Davs Hours Director 218-01-5145 88 9, 1919 Sep. Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examerar must be notified at any injury or other traumatic event, the Medical Examerar must be notified at any injury or other traumatic event, the Medical Examerar must be notified at any injury or other traumatic event. Director 1 ☐ Yes 2 X No MD Baltimore Halethorpe 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4801 Ruby Avenue 21227 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. if Yes, Give Year or Dates: 1945 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) 12 College (1-4or 5+) Supervisor Defense Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Goble Lillian Foster ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise A. Goble - Wife 4801 Ruby Avenue, Halethorpe, MD 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 7-2-2008 Baltimore, MD ure of Funeral Service Licenses 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has this certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. exam. 1 es Other: 4 Nursing Home 2 🗌 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Set Certification: After 1 Natural 5 ☐ Pending investigation 502 A eral Director: A 1 ☐ Yes June 28,2008 Gunshot wound 2 Accident 6 ☐Could not be 3 ☑ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 480 Ruby AUS Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home Md Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Division of Vital Records, P.O. Box 68760 within 24 hours a 10 /1

80

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SOZAM

State Registrar

31. Date filed (Month, Day, Year) 03

Signature

llo

of death (Item 28a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21524

Jeffrey Cissel Gra		- For State	Sta	te of Maryla	and / I	Departme <i>Certifica</i>			nd Men	tal Hyg	iene		200	18 2	2152
	R	egistrar 1. Decedent's Name	/First Middle	l act)		Certifica	ale oi	Dealli		12.	Date of Deat	g, No.	-	3. Time of I	Death
Physician Medical Examine	7.		rev Ci		auel						Month June 28, 2	Day 2008	Year	1510 h	
100		4a. Facility Name (if					4	b. City, Town,	or Location of				County of Deat	n	
ŧ		Rt. 198 & Br	ock Ridge l	Ridge Road				Laurel				ine Arundel			
Funeral		5. Social Security N		. Sex	7. Age (In yrs. last birt						th(MM/DI	D/YYYY) 9. Bi Forei	rthplace (Stat	e or
Director		219-21-2359 1XXM 2 F 41 Yrs. Months Days Hours N							Oct. 2	9, 1	966 C	gn Mary ountry)	Tand		
	<u> </u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d Inside	City Limits			
ow any		10a. State	10b. County			oc. City, rowii	Or Localit	, i							2 No
yland 1-f sh	핡	MD 10e. Street and Nur		George'	S	Laure	el	10f. Zip Code	9		1	0a. Citize	en of What Cou	untry?	
th the Maryland 23a or 28a-f show notified at once.	Director							2070				•	1107		
vith th		7518 Col	ntee Ro	12. Was De	cedent E	ver in U.S.		Decedent of	Hispanic Orig			- 1	USA 4. Race - Ame	rican Indian,	Black,
leath v	Funeral	XX Never Marrie	ed 2 Mar	ried Armed F		No	If Ye	es, specify Cul	oan, Mexican	, Puerto Ri	can, etc.)		White, etc.		
after d	ğ -	3 Widowed	4 Divo	ced If Yes, Give Ye	ar		1	Yes 2XX	No specify:				Specify: Wh		
natur	<u></u>	15. Decedent's Ed		fy only highest gra				's Usual Occu ost of working				16b. Kii	nd of Business	/Industry	
36 in 72 l han ",	ompleted	Elementary/Second		College (1-4 or 5+ Ø	· I	T		- One			77		1 #	7.7
-00. I with ther th	틹	17. Father's Name			yo .	nea	avy r	Equipme			irst, Middle,			ocal #	
21215-0036 Juld be filed within 7 Mental Hygiene. c event, the Medica	Be	Calv:			1161				Anr	n Garı	netta	Mil	ligan		
21, ould b d Men s mar lic eve		19a. Informant's Na				19	b. Mailing	Address (S	treet and Nur	mber or Ru	ral Route Nu	mber, City	y or Town, Sta	e, Zip Code)	
MD d 2 sho Ith and n 27 is numat	, L	Ann Garne		auel/Mot	her		7518		e Road		aurel, Date		20707 ocation - City o	Town Stat	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she of the reaumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Dis 1 X Burial 2		3 Removal f	rom Stat		of Dispos tory or oth	ition (Name of er place)	cemetery,	'	Date		_		•
Fage ment crant:		4 Donation 5	Other Spe	ecify:				lge Mem			/2008		kridge,		
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	1	23a. Part I. Enter th	MLCO	omplications that	caused t	M01103 ne death. Do n	ot enter th	3 Talb	ott Av	renue cardiac or r	 Lau espiratory ar 	rel, rest, shoo	MD 20 ck, or heart		mate Interval
Physician /Medical	-	fallure List on	ly one cause o	n each line. a Multiple In											n Onset and Death
xaminer	1	Immediate Cause (or condition resulting		Due to (or as		uence of):		•			-			1	
		Sequentially list co		b											
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	ă ă	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
				d	-			_						+	
	edical	UNPENDED AMENDED E FEMALE: 230 If yes, outcome of pregnancy								23d. Date of delivery					
Box 6876C he death certificate the attending physhed for use as the b	sician/M										Day	Year			
th cert	icia	past 12 months				and all all and be		her (Specify)				ļ			
Records, P.O. Box 6876 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the page 2.	≥	Part II. Other sign	Land	9 Uliki	nown	but not resultin	ng in the I	inderlying cau	se given in F	Part I.	23e. Did	tobacco i	use contribute	to the cause	of death?
of Vital Records, P.O. Bing Physician: The law requires that the dAfter this certificate has been signed by the timeral director, page 2 should be detached	و م	Part II. Other sign	nicani conuni	nis contributing	to death	Dut not resulti	ig iii tile t	inderlying odd	SC GIVOITIIT	GIV II.			No 3 P		
dS, duires	ted										24a. Was				ings available
COF	Completed	-									perf	opsy ormed?	death'		
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Division tal or Attendi rs after death. af Director: /	<u>i</u> g	2 Accident 3 Suicide		not be 28e. Pla	ice of Inj	ıry - At home,	farm, stre	et, factory, off	ice building,				nd Number or		Number, City
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	edical	29a. Certifier (Check only one)	Certifying Ph	ysician; To the b niner; on the basi	est of my	knowledge, de	eath occu	rred at the tim	e, date and p	olace, and o	due to the car the time, dat	use(s) an e and pla	id manner as s ace, and due to	tated. the cause(s)
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OCME 3		30 Nama and add	lade of sol	who completed an	use of de	eath (Item 23a)				_					
UCIVIE		30. Name and addless of person who completed cause of death (Item 23a) Mary G. Pupple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201													
Sta		31. Date filed (Mor				s Signature	1								
Registr	rar		UL 03	2008	Post of	, B	1400	W.		_					
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State of Maryland / Department of Health and Mental Hygien 2008

	Registrar			ertificate of			/-					
sician	1. Decedent's Name (First, Middle						2. Date of De Month	0	2008	Year	3. Time of	Deat
edical	Jean Gonzalez-			4b. City, Town,	or Location	of Death	0/		4c. County of	of Death	7:15	a
ıminer	9006 1st Stree			Lanhar		OI DOG!!!			rince		raela	
eral	5. Social Security Number		(In yrs. last birthda	ay) If Under 1 Yea	r If Unde	r 24 Hrs.	8. Date of Bi	rth			lace (State o	r For
tor	577 44 8214 Usual Residence of Decedent	1□M 2\\ F	82 Yrs.	Months Day	s Hours	Min,	9/2/1				sylvan	
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a	9006 1st Stree	t			20706 Un:					Stat	es	•
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Be	17. Father's Name (First, Middle,						(First, Middle		en Sumame	a)		
၉	Guiseppi Masci	arelli			Ele	na D'	Angelo					
	19a. Informant's Name/Relations			ailing Address (Stree						State, Zip	Code)	
	Jose A. Gonzal	ez		06 1st Sti		Lanha	m, MD	207	06			
once.	20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation	2 Demousl from State	20b. Place of Dis	sposition (Name of crematory or other p	lace)	D	ate	20c.	Location - 0	City or To	own, State	
	4 Donation 5 Other (S)		Ft. Linc	coln Cemet	ery	7/8/	2008	Bre	ntwoo	d, M	D	
DUC	21. Signature of Funeral Service	Licensee		22. Name and Add	ress of Facil	lity	4	739	Balt	imor	e Aven	ue
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	23a. Part1. Enter the disease, or	complications that caused t	the death Or and								Approximat	
		only one cause on each line	ine death. Do not e	enter the mode of d	ying, such a	s cardiac o	r respiratory a	ırrest,			Interval 8et	e wae
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year 300 A M **Physician** 2008 Baby Girl Gamez-Cantor ine /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 18, 5. Social Security Numbeunk 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) ^{Year)}2008 **Funeral** Days Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Director Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò 5142 Springhill Terrace #104 20770 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 72 hours after ò 1 ☐ Yes 2X No Specify Specify: white ş 3 - Widowed 4 - Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7's nd Mental Hygiene. I marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) event. 17. Father's Name (First, Middle, Last) Be Maria Gamez-Cantor es 1 and 2 should be of Health and Menta Item 27 Is marked ည traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 601 N. Wolfe Street Baltimore, MD Johns Hopkins Hospital 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 a
Department of He
Important: If Item
any Injury or oth 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 ☐ Cremation in state 4 ☐ Donation 5 N Other (Specify) State Andtomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Licenser RODALO S Baltimore, MD 21201 Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or com that it caused the shown or heart failure. List only one cause on each line. Immediate Suse (Final **Physician** treme disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any acting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has builtiector, page 2 s 2 🗌 No 2 □ No 1 TYes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X 2 ER/Outpatient 3 DOA ၉ funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident death. 3 Suicide 28f. Location (Street and Number or Rural Route Number,

Box 68760, P.0. Division of Vital Records, or Attending Drector filled in by 24 hours

Baltimore, Maryland 21215-0036

Certification: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JULIA

0,0 TRINTIS 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6,0

within 2

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JUNE

600 North Wolfe St, Baltimore, MD, 21287

25, 1008

			For State Registrar	State of Mar	yland / De	epartment of F Certificate of I	Death	/lental Hygi	^{ene} 200	8 21527		
П	Physici		1. Decedent's Name <i>(First, Middle, La</i> Kay Ma	_{st)} rie Gonzal	es			2. Date of Death June	_	3. Time of Death 11:05 pM		
1	/Medid Examin		4a. Facility Name (If not institution, given Sunrise of Pike			4b. City, Town, or Pikesvil	Location of Death		4c. County of D			
I	Funeral Director		170-14-0502	Sex 7. Age 1 ☐ M 2 💢 F	8. Date of Birth (Month, Day, Dec. 29,	Year) 918 F	Birthplace (State or Foreign Country) ennsylvania					
	Maryland a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Md. Baltimo	I	Oc. City, Town o					10d. Inside City Limits 1 □ Yes 2 X] No		
	ING 21215-0036 be filed within 72 hours after death with the Maryland hal Hygiene. dother then "natural", or items 23a or 28a-f show event, it a file alcal Exp. wirst must be positived at		10e. Street and Number 3800 Old Court	Road	-	10f. Zip Code 21208		10	g. Citizen of What	Country?		
9036	ours after des ral", or items Extrailmer in	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, /hite, etc. White		
Baltimore, Maryland 21215-0036	within 72 ho liene. r than "natu is e Medical	Completed	15. Decedent's E (Specify only highest grant properties) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+) +2		ecedent's Usual Occup Give kind of work done of ife. DO NOT use retired OOKKEEPET	ation during most of work f)	ing	6b. Kind of Busine			
/land	uld be filed Mental Hyg arked other atic event, l	To Be C	17. Father's Name (First, Middle, Last George Nosich	18. Mother's Name	Neslani	,						
, Mar	and 2 sho salth and 27 Is ma er trauma		19a. Informant's Name/Relationship (Mrs. Debbie Abram	**	- 1	Mailing Address (Street 428 Diana F				te, Zip Code)		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it we flexible as a single be profitted at any injury or other traumatic event, it we flexible as a single as a singl			Mrs. Debbie Abramson/ Daughter 2428 Diana Rd. Baltimore, Md. 21209 20a. Method of Disposition 1									
Bai	permit Depar Impor any in		21. Signature of Fuperal Service Lice	15/5		22. Name and Addre RUCK TO 1050 Yo						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or as a ob.	EMF consequence of)	Y71A	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death		
68760,<	incate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C								
	attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date of Month	delivery Day Year		
rds, P	v requires that the deben signed by the should be detached	þ	Part II. Other significant conditions		te to the cause of death? Probably 4 Onknown							
Vital Records,	r ne law re cate has ber page 2 sho	Completed						24a. Was an autopsy perform 1 □Yes 2	ed? prior	e autopsy findings available to completion of cause of h? Yes 2 □ No		
Vita	certificate rector, pag	Be (25. Was case referred to medical examiner?	Henrital		Tou		h (Check only one)	A 1-		
ō	rthis ral dir	£:	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outp	atient 3 DOA Other	4 Li Nursing Ho	ome 5 Resider	,	Specify) HSSISTED LIVI		
Division of	rospina or Artending Priysician: 24 hours after death. Funeral Director: After this certified kely filled in by the funeral director; p	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	(Month, Day,)	/ear) Inji	ury Worl	Yes 2 □ No		eet and Number o	r Rural Route Number,		
	or the rospitar of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer		nysician: To the best of miner: On the basis of e	my knowledge, oxamination and/	death occurred at the til						
	vithin To the compl	Me	29b. Signature and title of certifier	bl.	1/1/5	29c. Licens	e number		d. Date signed (M	onth, Day, Year)		
	5			completed cause of dea	th (Item 23a) (Ty	Print) RIVER N	leur 145	# 109	BALTII	nore		
	Sta Registr		31. Date filed (Worth, Day, Year) JUL 0 3 2	32 egistrar	S Signature	free						

DHMH 17 Rev 1/2001

ORIGINAL

arry Gold		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2008 21528											
Physician edical Examin	n/	Registrar 1. Decedent's Name (First, Middle BARRY	e,Last)	S		GOLD		2. Date of Dea Month June 30, 2	th Dav Year		of Death 6 hrs		
		4a. Facility Name (if not institution Sinai Hospital	n, give street and number	r)	4	b. City, Town, c Baltimore	or Location of		4c. County of Death N/A				
Funeral Director	- 1	5. Social Security Number 220-44-4945	6. Sex 7. A	ge (In yrs. la 61	st bi rt hday) Yrs.	If Under 1 Ye Months Da		24Hrs. 8. Date of Bi Min. 02/25/		. Birthplace (preign Country)	1		
id how any Ee.		Usual Residence of Decedent 10a, State 10b, County MD BALT	10c. City, Town or L			on BALTIN	MORE				side City Limits Yes 2 X No		
death with the Maryland or items 23a or 28a-f show any must be, notified at once,	Director	10e. Street and Number 3410 WOODVALLE	EY DRIVE				21208		10g. Citizen of What	Country?			
death w	Fune	11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 Div	12. Was Deceder Armed Forces 1 X Yes orced If Yes, Give Yeer		If Y	S Decedent of Hes, specify Cub.	an, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - A White, e Specify:	merican Indian, Black, c. WHITE			
16 n 72 hour nan "natt	Completed by	15. Decedent's Education (Spec Elementary/Secondary (0-12)		College (1-4 or 5+)			pation (Give ki fe. DO NOT u	nd of work done se retired)	16b. Kind of Busin				
ID 21215-0036 should be filed within 72 and Mental Hygiene. 77 is marked other than natic event, the Medical	B	17. Father's Name (First, Middle, JOSEPH	ANSKI			1	Name (First, Middle,	G01					
nore, MD 21 ages 1 and 2 should ent of Health and Mc nt: If item 27 is ma	<u>و</u> ا	19a. Informant's Name/Relations LINELL GOLD / 20a. Method of Disposition	/ WIFE		3410	WOODV	ALLEY I	DRIVE, BAL Date		D 212	.08		
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		1 X Burial 2 Cremation 4 Donation 5 Other St. 21. Signature of Funeral Service	pecify:		TIMORE 22. N	HEBREW	ess of Facility	07/02/2008 SOL LEV TOWN ROAD	INSON & B	ROS.,	INC.		
Physician Medical was and russit	al Examiner	23a. Fart / Errier the disease, of ailure. List only one cause Imme ate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor b. Due to (or as a cor c. Due to (or as a cor d.	Atheroscl nsequence o	erotic Card			rdiac or respiratory a	rrest, shock, or heart	Appr	oximate Interval veen Onset and Death		
e e e	ysician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	I LIVE BIRTI	at time of de	2 Fe	etal death ther (Specify)	3 Ectopic	pregnancy	23d. Date of de Month	elivery Day	Year		
P.O. es that the igned by the detached	Completed by Phy	Part II. Other significant condi	tions contributing to de	eath but not r	ot resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown 24a. Was an autopsy performed? 1 Yes 2 ✓ No 1 Yes 2 No				
in of Vital Records, ding Physician: The law require. In the this certificate has been se tuneral director, page 2 should be	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pen		Injury	26.Place of Death (Check only one) 26.Place of Death (Check only one) Provided Fraction (Check only one) 26.Place of Death (Check only one) Other 1 Nursing Home 5 Residence 6 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No					Other:			
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	2 Accident Inve 3 Suicide 6 Cou 4 Homicide	28e. Place of Specify)			eet, factory, offic		uilding, etc. 28f. Location (Street and Number or Rural Route or Town, State)			ute Number, City		
To the Hos within 24 h To the Fun completely	Medical		aminer:On the basis of e and manner state	examination a	ledge, death occurred at the time, date and place, and due to nand/or investigation, in my opinion, death occurred at the 29c. License number				me, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)				
0		30. Name and address of person Patricia Aronica-Polla			مر ساوی n 23a) Examiner		C.M.E. Street, Ba	altimore, MD 212	July 1, 2008				
St	ate			strar's Amnat	ture	0							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Redden Oliver Houck, Srl /Medical 4a. Facility Name (If not institut) give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner no mittle 5. Social Security Number 8. Date of Birth Feb. 3, If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Yef 948 214-50-2510 60 Marvland Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10h Counts 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or? 21223 2407 Christian Street United States r than "natural", or items 23s the Medical Examiner must Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify. Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) A 27 is marked other than "... rtraumatic even* *** Overnight Elementary/Secondary (0-12) College (1-4or 5+) 10 Dock Worker Transportation Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumost-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Houck Beulah Bowser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Houck - Wife 2407 Christian Street, Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Zion Cemetery 6-30-3008 Lansdowne, MD of Funeral Service Licenses Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Ecquer tiully list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and The law requires that the death certificate be execu Due to (or as a consequence of) Physician/Medical as IF FEMALE for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3 Probably 4 □Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 0 this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? vision 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) Smith, Rachelle 29b. Signature and title of certifier 10060088 more 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 32. Regis rar's Signature Murphy 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23a PtII,25,28c,d per me 881 0//02/08dhb Registrar Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ves **Physician** Richard A. 5.14 PM HICKS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dt 104 Baltimore trai If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 217-34-8509 Days Months 1 M 2 F Hours Bottimore Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ns 23a or 28a-f shov 1 Nes 2 No mi NIA altimore Funeral Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21202 110 N 'entra 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Items 14. Race - American Indian, 11. Marital Status 7 is marked other than "natural", or item traumatic event, the Medical Examiner. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Known As: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify: Black Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Labor aintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ucneva_ ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patient 19a. Informant's Name/Relationship (Type. Print) 27 Is I Day Walt Ave Baltimae daughter 5411 permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra once. 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, MD 25/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howell Furieral 21. Sign ure uneral Service incenses 3331 Brehms Baltimore, MD 21213 Lane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Caroltallain Physician Coronary Artery Discase /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPOROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ due to Boerhaave Syndrome perforation 1 Yes 2 No 3 Probably 4 Unknown Completed 724b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2[1 □Yes npletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within 2

To the I

complet and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30142 Totalatrick MD June 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J LAWFENCE Fitzpatrick MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

#28c, a+30

Richard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21531

		1- For State Certificate of Death Reg. No.								2100			
Physicia	1/ 1	. Decedent's Name (First, Middle,Las							Date of Deat Month	Day	Year		e of Death 15 hrs
ledical Examin		WILLIAM		HERGET		00 T			June 26, 2		nty of Dear		131113
	4	a. Facility Name (if not institution, giv Harford Memorial Hospita			4	b. City, Town Havre de		Harford					
Funeral		5. Social Security Number 6. S		e (In yrs. last b	irthday)	If Under 1	rear If Und	er 24Hrs.	8. Date of Bir	th (MM/DD/Y	γγγ) 9. B	irthplace	(State or
Director	- 1		M 2 F	70	Yrs.	Months [ays Hour	s Min.	Feb. 1	5,1938	B Fore	ign :ountry)M	laryland
Á		Jsual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	on			_			10d. I	nside City Limits
ow any		Maryland Harf	ord	too. Oily, too.		erdeen						1 [Yes 2 No
Aaryland 28a-f show i at once.	o L	10e. Street and Number	014			10f. Zip Cod			1	0g. Citizen o	f What Co	untry?	
th the Maryland 23a or 28a-f sho notified at once.	Öİ	Spesutia Road				21001				U.S	S.A.		
with the s 23a s 23a e noti	- L	11. Marital Status	12. Was Decedent		13. Wa	s Decedent of	Hispanic Or	gin? (Spec	ecify Yes or No- 14. Race				tian, Black,
leath ritem	Fune	1 Never Married 2 Married	Armed Forces?	No	If Y	es, specify Cu	ban, Mexica	n, Puerto Ri	can, etc.)		Vhite, etc. Whi		
after call, o			d If Yes, Give Year or Dates:			Yes 2				Spec	arty:		
hours a		15. Decedent's Education (Specify of		<u> </u>	a. Deceden during m	t's Usual Occ ost of working	ipation (Give life. DO NO	Kind of wor Luse retired	rk done d)	16b. Kind o	if Busines:	s/industr	,
36 in 72 han "	Elementary/Secondary (0-12) Solution of working life. DO NOT use reting the property of the p								Un:	ion E	roth	ners	
5-0036 iled within 7 Hygiene. I other than the Medica	탉	17. Father's Name (First, Middle, Las	t)		18.Mother's Name (Fi				irst, Middle,	Maiden Surn	ame)	ne)	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sh matic event, the Medical Examiner must be notified at once	Be	Robert	A. Herget	t				lora	Ε.	Larse	_		
2121 rould be fi d Mental is marked		19a. Informant's Name/Relationship (g Address (S							
MD nd 2 sho alth and m 27 is	-	James Herget 20a. Method of Disposition	(Brother)	20h Plac	417	Cambri	a Stre		Saltimo Date	ore, Ma	aryla tion - City	or Town	State
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the <u>Medical</u>		1 Burial 2 Cremation 3	Removal from St	crem	natory or otl			l		Glen	Barr	nio	Maryland
timent rtant:		4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		Gien									
Bal permi Depar Impo		21. Signature of Funeral Service Lice	risee V		Mo	Cully- 37 East	Polyn	Tak Fu	ineral	Home .	P.A. imore		21225 aryland
Physician	-	23. Part I. Enter the disease, or com	plications that caused	the death. Do	not enter t	he mode of dy	ing, such as	cardiac or i	respiratory ar	rest, shock, o	or heart	App	proximate Interval
/Medical	4	failure. List only one cause on e Immediate Cause (Final disease	each line. _{a.} Hypertensive A	therosclero	tic Card	iovascular	Disease						Death
kaminer		or condition resulting in death)	Due to (or as a cons										
		Sequentially list conditions,	Due to (or as a cons	canonce of/:				_				+	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c.	equerice ory.									
E - 611	Ха	events resulting in death) Last	Due to (or as a cons	equence of):									
recut - tra		LIMBENDED	AMENDED						-	-		+	
760, icate be execut physician and the burial - tra	Medical	UNPENDED	23c. If yes, outco	mo of prognan	101/					23d, Da	ate of deliv	verv	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	ine or pregnan		etal death	3 Ecto	pic pregnar	псу		nth	Day	Year
Box 687 e death certifi the attending ed for use as t	sicia	1 Yes 2 No 9 Unknow	_ -	t time of death	5 0	ther (Specify,				·			
b.O. Bc that the de- ned by the a detached fi	Physician	Part II. Other significant conditions	9 OHKHOWIT	th but not resu	Iting in the	underlying ca	use given in	Part I.	23e. Did	tobacco use	contribute	e to the c	ause of death?
P.O es that to igned by oe detac	à	Prostate Cancer	3		Ü				1 🗌 Y	es 2 No	3 F	² robably	4 V Unknown
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n of Vital Records, Ling Physician: The law requir After this certificate has been si funeral director, page 2 should I	<u>۽</u>	27. Manner of Death	28a. Date of Inj (Month, Day,		Bb. Time of		. Injury at W		28d. Describ	e how injury o	occurred		
ion tendir eath. for: A	Ē	1 V Natural 5 Pending 2 Accident Investigation		,		1	Yes 2						
Division tal or Attendi rs after death. al Director:	Certification:	3 Suicide 6 Could no	ot be 28e. Place of I	njury - At home	e, farm, stre	eet, factory, of	fice building	etc.	28f. Location or Town		Number o	r Rural R	oute Number, City
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To t With Com	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the component of th										e signed		
O.C.M.E.										July 1	2008		
	-	30. Name and address of person wh	o completed cause of	death (Item 23	Ba)			7	_				
L. F.		Patricia Aronica-Pollak N		Medical Ex		111 Pen	n Street,	Baltimor	e, MD 212	201			
St	ate	31. Date filed (Monte, Day, Year)		ar's Signature	k A	mark o							
Regist	rar	JOE 0 0	2008	was N	250	ADVEN							

The critical areas illastrate that	Tile Tile Cobioc Michael
State of Maryland / Department of He	ealth and Mental Hygien UU

hysici	an	1. Decedent's Name (First, Middle, Las Gerald R. Howard	st)		incate	of Death	2. Date of De		Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, given 827 Dora P1	e street and number)		4b. City, Town, or Location of Death Bel Air			4c. County of Death Harford		
ineral rector		Social Security Number 6. S	ex 7. Age (In € 5	yrs. last birthday) Yrs.	If Under 1 Y	ear If Under 24	Hrs. 8. Date of Bin (Month, Da 08-22-	th v. Year)		ace (State or Fore
		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo	ocation		00 22		10	0d. Inside City Lim
be notifie	Directo	MD Harford 10e. Street and Number		ir 10f. Zip Code			10g. Citizen of	What Coun	1 □ Yes 2 🔀 try?	
portion: Tagger Fairly and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	827 Dora P1 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1		21014 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc			Sor No- asc.) 14. Race - Americ Black, White, Specify: White		etc.
Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual O kind of work of DO NOT use r	one during most o	f working	16b. Kind of I	Business/Ind	ustry
event, the	Be	12+ 17. Father's Name (First, Middle, Last)		Operations Manager		Name (First, Middle,	Maiden Suma	strial		
27 le marke r traumatic	2	Robert Howard 19a. Informant's Name/Relationship (Carol Howard (Wife	* 1		-	reet and Number	erine Whet: or Aural Aoute Number, MD 21014	er, City or Town	n, State, Zip	Code)
int: If item:		20a. Method of Disposition 1 ↑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Specify	Inemoval hom State	Db. Place of Dispo cemetery, crea	sition (Name on matory or other	of r place)	Date 7-03-2008	20c. Location		
eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Hom Inc. 610 W. MacPhail Rd Bel air, MD								of BelA
ician dical niner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	on any c	er the mode of	dying, such as ca		rrest,	Ý	Approximate Interval Between Onset and Death
onysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conduction of the conduction							•
by the ettending physitached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\times \) Yes 2 \(\times \) No 9 \(\times \) Unknown	23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregn Other (specif				ate of deliver	ry Day Year
e o o	ρ	Part II. Other significant conditions of	ontributing to death but not	t resulting in the u	nderlying caus	e given in Part I.		23e. Did tobacco use contribute to the cause of		
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direct	To B	examiner?	Hospital:	2 🖺 ER/Outpatier	at 3□ DOA	Othor	ng Home 5 Resid		her (Specify	1
nera nera	Certification; T	27. Mann r of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe I	now injury occu	rred	
the Fu	Medicai	ane)	niner: On the basis of exam and manner stated.	mination and/or in	vestigation, in	ny opinion, death	occurred at the time,	date and place	, and due to	the cause(s)
9 5	2	29b. Signature and title of certifier	Weng n	10	10	5076	0	29d. Date sign	-08	
/		30. Name and address of person who	4			k RU.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 27, 4:21 PM 2008 CATHERINE MARGARET HOFFMAN June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 7920 West End Drive Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 🗹 F 09/03/1914 93 Maryland Director 215-18-6012 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director Baltimore MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S<u>.A.</u> 7920 West End Drive Funeral 21226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛂 No þ Specify. 3 ₩Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Helen Guilfoy Frank Merrit Hook 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Stephen Hoffman / Son</u> 4114 Whitelyville Road, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State 07/02/08 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 3 years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsv performed: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are To the Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier address of person who comple ed cause of death (Item 23a) (Type, Print) Pennington, Ave. Balto. Md 2126 MID. (Month, Day, legistrar's Signature State 2008 Registrar

Þ	For State State Registrar 1. Decedent's Name (First, Middle, Last)	eartment of Health and Mertificate of Death							
sician edical	Marie Herman		July 1 2008 11:45						
miner	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice	4b. City, Town, or Location of Death Timonium If Under 1 Year If Under 24 Hrs.	4c. County of Death Baltimore						
eral tor	5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday 7. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) Pennsylvar						
tor	10a. State PA Adams 10b. County Gettysbu		10d. Inside City 1 ∐Yes 2						
To Be Completed by Funeral Director	10e. Street and Number 338 Ridge Avenue	10f. Zip Code 17325	10g. Citizen of What Country?						
Funera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I							
eted by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 15. Decedent's Education [16a. Dec (Specify only highest grade completed) [Giv	1 ☐ Yes 2 🛛 No Specify: edent's Usual Occupation be kind of work done during most of working	Specify: White						
Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Teac	DO NOT use retired)	Education						
To Be	17. Father's Name (First, Middle, Last) Gust Melissas	18. Mother's Name Mary Yet	(First, Middle, Maiden Surname) SSCOnish						
		ing Address (Street and Number or Rura en Highland Court,	Route Number, City or Town, State, Zip Code) Phoenix, MD 21131						
h		ematory or other place)	ate 20c. Location - City or Town, State 5–2008 Monessen, PA						
once.			Towson Funeral Home, Inc						
n	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.								
al er	disease or condition resulting in death) LYMPHOMA Due to (or as a consequence of):								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events c.								
edical Exa	resulting in death) Last Due to (or as a consequence of): d.								
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δ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ur						
Completed			24a. Was an autopsy performed? 1 □Yes 2XNo 24b. Were autopsy findings an prior to completion of care death? 1 □Yes 2 □No						
To Be	25. Was case referred to medical examiner?	26. Place of Death ent 3 DOA Other: 4 Nursing Hor	(Check only one) ne 5 ☐ Residence 6 🗶 Other (Specify) HOSPI						
Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 28d. Describe how injury occurred Work? 1 yes 2 No 28d. Describe how injury occurred Work? 1 yes 2 No 28d. Describe how injury occurred work?								
edical C	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.								
Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) 7 / 2 / 0 8						
2	30. Name and address of person who completed cause of death (Item 23a) (Type DR. TARIQ MAHMOOD 23Q0 DULANEY VAI								

JULY 1, 2008 11:45 p.m.

			State of Maryland / Depar	tment of Health and ificate of Death	Mental Hy	$^{\text{giene}} 2008$	21535
	4 1 8		Decedent's Name (First, Middle, Last)		2. Date of D Month		3. Time of Death
	Physicia /Medic		Mary G. Hanson		July	2 2008	2:15 A M
	Examin			4b. City, Town, or Location of Dea	ath	4c. County of Deal	
			Oak Crest Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Parkville If Under 1 Year If Under 24 Hr.	s. 8. Date of 8	Baltin irth 9. Bir	holace (State or Foreign
J	Funeral Director		213-14-3773	Months Days Hours Min	8. Date of 8 (Month, D	-1922 Mar	yland
NK _	P .		Usual Residence of Decedent	ation			10d. Inside City Limits
0	ehov	or					1 ☐ Yes 2 X No
8	the N 28a-f	ecto	MD Baltimore Parkvill 10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	buntry?
STC SolelL	be itled within 72 hours after death with the Maryland Hygiene. All Hygiene and other than "natural; or Iteme 23e or 28e-f show event, the Madical Examinar must be nailified at	Funeral Director	8830 Walther Blvd., #328 RTG	21234		U.S.A.	
10	death	ners	11, Marital Status 12, Was Decedent Ever in U.S. 13, W. Armed Forces?	as Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	Io- 14. Race - Ame Black, Whit	encan Indian,
36	72 hours after natural', or Ite olest Examire	by Fu	1 Never Married 2 Married 1 Yes 2 No	☐Yes 2X☐No Specify:		Specific	hi te
2-003و	hour tural		15 Decedent's Education 16a, Decede	ent's Usual Occupation		16b. Kind of Business	
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子 12	filed within 7 Hygiene. other than "r	Com	12 Home	Maker		Own Home	
→ □	12 should be fited within h and Mental Hygiene. 7 is marked other than " rearmatic svent, the Mac	Be	17. Falher's Name <i>(First, Middle, Last)</i> Mathew Blaine			_{le, Maiden Sumame)} Line Sarbach	
Maryland	hould d Men narke natic	2		Address (Street and Number or F			
Mal	s 1 and 2 should f Health and Men Item 27 is marke other traumatic			Walther Blvd.,	#328 R		,
1 (D)	ges 1 and 2 t of Health if Item 27 or other tra		20a Method of Disposition 20b. Place of Disposi	tion (Name of	Date	20c. Location · City or	
303 Hz. Baltimore,	permit. Pages 1 Depertment of the Importent: If Ite any Injury or of any Injury or ot any Injury or ot any Injury or ot		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify Memorial	Gardens	' - 07-2008		n, Maryland
303 Baltim	armit. apertr porte ny Inju					vson Funeral	
3 =	20 E = 9			.050 York Road,			.204 Approximate
9			23a. Part. Effer the Isease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardi	ac or respiratory	arrest,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. A S C V D Due to (or as a consequence of):				
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	ecuted and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):				
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Э.	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/M		Other (specify)		Month .	Day Year
P.O.	that the dead by the detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Dio	d tobacco use contribute t	o the cause of death2
Division of Vital Records,	uires that signed to id be det	d by	End Stage Dementic		10	Yes 2 No 3 ₽	robably 4 Dunknown
CO	s been si s bould	Completed			24a. Wt	as an 24b. Were a	utopsy findings available
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of V	Physic this ce al dire	2	1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			sidence 6 Other (Sp.	ecify)
uo	ding f h. After funer	tlon:	27. Manney of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation (2.1)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describ	e how inju ry occurred	
<u>isi</u>	Atten r deat actor: by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - Al home, farm, stre			(Street and Number or F	Rural Route Number,
ä	s afte el Dire	Cert	4 Homicide determined building, etc. (Specify)		City of	own, State)	
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Madical Examiner: On the basis of examination and/or invegand manner stated.				
	To the within To the	Me	29b. Signalure and title of certifier	29c. License number		29d. Date signed (Mor	th, Day, Year)
			amono	058646		July	2 , 2008
	20		30. Name and address of person who completed cause of death (Item 23a) (Type, F)	0 1	1.5.5.5
90	To		Anna Monias 6800 W. 31. Date filed (Month, Day Year) 32. Registrar's Signature	althor Bou	know	MONKUITE,	MU51534
	Sta Registi		31. Date filed (Month, Day Year) 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JuMonth **Physician** 029 2008 6:40 а м Ellen ٧. Hanson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Health and Rehab. Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F Months Days Hours 220-09-4288 87 Director Jan.17<u>,1921</u> Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If time 72 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is fructive for any injury or other traumatic event, it is fructive for a first must be notified at Director 1 □Yes 2√□No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1820 Miller 21030 Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Telephone Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Auffarth Alma Moodv ೭ George H. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shrewsbury Pa. 17361 12 Bridle Road Harriett Lloyd / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gds. of Faith Cem. 7/5/08 Overlea, Maryland 21. Signaturi of Fundal conce Licanee ²² Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. cer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List/only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IMERS **Physician** DISTAST ZHE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or his a consequence of) Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ficate has been sir, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes 2 ☑No : After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠wNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A pletely filled in by the fu 2 Accident investigation ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Anny Was 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POTER St. BALTIMORE, MD 21225 K.S. DHARMASENA, M.D. 3721 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician SYLVIA HARFST /Medical 07:00 A M JUNE 24, 2008 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BELAIR Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F Months Days Hours Director 108-14-4329 DEC. 1,1919 NY Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examiner must be notified at 10d. Inside City Limits Directo WESTCHESTER CORTLANDT 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 KINGS FERRY RD, MONTROSE 10548 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or thealth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 2 🔽 No Specify: 3 ₩idowed 4 Divorced WHITE Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CASHIER FOOD STORE Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည PETER CUNNINGHAM IDA McPARTIAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is MARY LOU LOEBER-DAUGHTER 202 K BURKWOOD COURT BELAIR, RD 21015 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. PATRICKS CEM. 6/28/08 4 Donation 5 DOther (Specify) VERPLANCK, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enter the diseas shock, or heart fail use Immediate Cause (Fina disease or condition resulting in death) the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line. **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1∐Yes 2XXNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending s after death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the within 2 29b. Signature and title of certifier

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Registrar

31. Date filed (Month, Day, Year) Registrar's Signature ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200821538 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 14:35 PM weldon 2008 GCK501 /Medical 4a. Facility Name (If not institution, give street and number) Palt in occ 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA Kehabilitahon OFE care center Extended 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 □ F 212-14-0198 APRIL 15,1907 101 MARYLAND Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov ral", or items 23a or 28a-f shov Even it out to notified at 1 ☐ Yes 2 MNo Funeral Director BALTIMORE GWYNN OAK MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3406 KESTON ROAT permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No þ Specify: BLACK 3 X Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PEABODY INSTITUTE DOMESTIC ENGINEER GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SUSIE JACKSON (MN-UNKNOWN) ISSAAC ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3406 KESTON RD, GWYNN OAK, MD QIQDT COCHRANE GRANDDAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State BALTIMORE NATIONAL CEM. 07-08-2008 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOSEPH H. EROLDN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 5+425 **Physician** men disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 ţ. attending properties for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) TYPS 2 No. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sh autopsy performed? Yes 2X No Division of Vital 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred funeral 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title 0790 10 21218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Civarios

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gistrar's Signature

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			, reg. et al.	ificate of Death	Reg. N	<u>,2000 21333</u>
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Hannelore L. Kahl	į.	July 1	3. Time of Death 2008 5:20 4 M
>	Examir	er		b. City, Town, or Location of Death Fallston		c.County of Death Harford Co.
i.	Funeral Director			If Under 1 Year If Under 24 Hrs. 8, Months Days Hours Min. Min.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) 931 Germany
	e Maryland Ba-f show tifled at	Director	10a. State 10b. County 10c. City, Town or Local	Iston		10d. Inside City Limits 1
	with th		10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🖾 No	as Decedent of Hispanic Origin? (Specifies, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
12-0	72 hou "natura		(Specify only highest grade completed) (Give kir	nt's Usual Occupation and of work done during most of working		Kind of Business/Industry
2121	d within giene. ir than " the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Re-	NOT use retired)		eta Shoe Company
and	i be filed ntal Hygi ed other event, ti	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
Maryland 21215-0036	2 should be and Menta Is marked aumatic ev	P P	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing.	Address (Street and Number or Rural F	Route Number, City	or Town, State, Zip Code)
e,⊠	1 and 2 Health tem 27 I		Francis Kahl - Spouse 1200 20a. Method of Disposition 20b. Place of Disposition	wild Orchid D	rive Fo	Ulston MD 21047 Location - City or Town, State
Baltimore,	Pages nent of I ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ☐ Highview	tory or other place)		Uston, MD.
Balt	permit. Pages 1 an Department of Heat Important: If item 2 any Injury or other once.		21 Signature of Funeral Service Licenses	Jame and Address of Facility		non Services-Belair non Maryland 21050
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Concession VE Due to (or as a consequence of):	HEHRT FAILURE	F	Onset and Death
	Examiner		IS CHEMIC 1	HENRY DISTINCT	5	
4	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
, 00°	ficate be executed physician and s the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):			
68760,	ficate by physic is the b	edical	d			
P.O. Box	The law requires that the death certif ite has been signed by the attending age 2 should be detached for use a	Physician/M		ctopic pregnancy other (specify)		23d. Date of delivery Month Day Year
	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the under CHRONIC ENDSTAGE KIDNEY Z			use contribute to the cause of death?
Division or Vital Records,	n: The law ricate has be	Completed			24a. Was an autopsy performed? 1∐ Yes 2€	
۲ Vit	ysiclan: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (C		6 ☐Other (Specify)
sion o	To the Hospital or Attending Physician: The within 24 burs after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		27. Manner of Death 1		I. Describe how inj	
<u> </u>	tal or Attendest is after death al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	t, factory, office 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigated.			
		M	29b. Signature and title of certifier Andrew Nowelman's MID	29c. License number D0 8096	TU	eate signed (Month, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Andrew Nowakowski MD 35	FULFIND AUD 1	Belain	mp 21014
ï	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Andrew Nowakowski MD 35 31. Date filed (Month, Day, Year) 32 Registrar's Signature	W		

State of Maryland / Department of Health and Mental Hygiene 430, perDVR, g881, 7/3/08 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 June 30. Kotmair Delma Martha /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Westminster <u>Hidden Treasure Assisted Li</u>ving If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🔽 F July 20, 1912 Maryland Director 215-03-9970 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Midical Experiment must be rediffed at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Queen Annes Centreville 1 ☐ Yes 2 🛂 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 202 Opera Court 21617 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify: Specify: 2 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Binder Publisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shelt Leifert Lena Juluis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 202 Opera Ct., Centreville, MD 21617 Nancy K. Frey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Loudon Park Cemetery 7/3/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Put Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (ARDIOVISAVAR RTORIOSCURATE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nding physician and use as the burial-transit Due to (or as a consequence of) Box 68760. or Attending Physician: The law requires that the death certificate be after death. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for i Month Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □ Yes 2 🖪 No 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury at Work? After To the Hospitar or within 24 hours after death.

To the Funeral Director: Aft and the Funeral Director of the Funeral Director of the furnity filled in by the furnity filled in the furnity 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide l 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 1)20806 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Turnes, MD Hidden Treasure Assisted Living Westminster, MD Patrick A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 3 2008 See & Sparke Registrar

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GEETHA RAJA MD, 4367 Hollins Ferm Rd, Slike 4A, Baltimon, MD-21227

ORIGINAL

Registrar

Credna Lega MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Blown & Spelle

State of Maryland / Department of Health and Mental Hygien 🔊 🛭 🕦 🖇 21542 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12/5 PMM **Physician** Louise Cecelia July 1 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care- Ruxton Baltimore
If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Virginia **Funeral** Days Hours Min 1 ☐ M 2 ☐ F Director 212-36-2130 Dec. 24,1917 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 ☐ No Director Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8258 Bullneck Court Funeral 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 is marked other than ". Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Fox Lillian Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is, any injury or other traus Louis J. Danna/ Grandson 8258 Bullneck Ct. Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 7/8/08 Towson, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE Pnysician eas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) the o ģ signed t d be deti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After the Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Io 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 555W. Towsartown Blud dall aulkner MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Come Miles **Physician** 2008 /Medical 4c. County of Death
Balh moin 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Season's Hospice Randallstown Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 08 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Min. Year) 1 ☐ M 2 🕏 F 116-18-4668 Director 12 95 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Marical Examinating the notified at once. 10a State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ∐Yes 2 🔀 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Winters Lane Apt 413 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 📉 No Specify: Specify: Black 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
3rd grade College (1-4or 5+) Janitorial Work Factory na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Edward Waters Sudie Sterling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Mt. Holly Street, Baltimore, Md 21229 Edward Young-Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/5/08 Mt. Calvary Glen Burnie, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** renaliell waining /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a second of the later cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Dual to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo Year Day 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably **J**Unknown rennaeval vusculor divar 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl 24a. Was an autopsy perform 1 □ Yes 2.0 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 D Natural 2 D Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 0006068 D 12009

9√

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 3 2008

30. Name and address of



person who completed cause of death (Item 23a) (Type, Print)

Reisterstun,

			For State Registrar	State of Marylan		artment of H		, 0	ene a. No. 2008	21544		
c	Physici		1. Decedent's Name (First, Middle, Last) Betty	Louise M	larcian	te		2. Date of Death June 26	2008 Year	3. Time of Death 6:15 A _M		
13	/Medio Examir		4a. Facility Name (If not institution, give st Tate Chesapeake		ıse	4b. City, Town, or Linthicu		th	Ac. County of Death Anne Arundel County			
Ì	Funeral Director		5. Social Security Number 220–22–9353 6. Sex	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birthplace (State or Foreign Country) Maryland			
	rland ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				0d. Inside City Limits		
	he Man 8a-f sh otified	Director	Maryland N/A		Ba1	Ltimore		140	Oiting of William Court	1 Yes 2 No		
	ath with t	ral Dir	10e. Street and Number 1519 William S				21230		g. Citizen of What Cour			
920	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2🌠 No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Whi	etc.		
15-0	d within 72 ho giene. r than "natur the Medical	Completed	15. Decedent's Educa (Specify only highest grade	completed)	16a. Deced (Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking 10	6b. Kind of Business/Ind	lustry		
212	ed within ygiene.	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		eceptionis	st	l	Mercy Hospi	tal		
land	should be fill nd Mental H marked oth matic even	To Be	17. Father's Name (<i>First, Middle, Last</i>) Albert Prid	geon			Sara	me (First, Middle, Mi Fisher	aiden Surname)			
Maryland 21215-0036	2 s is is		19a. Informant's Name/Relationship (Type Deborah Marciante K	Print) (daughter	r							
	1 an Heal em 2 ther		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Re	20b. F	Place of Dispo cemetery, crer	sition (Name of matory or other plac	ce)	Date 2	adena, Mary Oc. Location - City or To	wn, State		
Baltimore,	Pa Fige Pa		4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service Licensed	Lec	/	1 Cemeter			rooklyn Par			
Ba	permit. 1 Departm Importal any Inju		June &	Xxml	13	30 East F	ort Aven	uneral Hor ue, Baltin	me P.A. more, Maryl			
8760,78	Physician /Medical Examiner physician and physician and the prinal-transit physician by the prinal physician and p	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	uence of):	ART ALH & ME	ERY	DISEA	YSION.	Approximate Interval Between Joseff and Death S		
O. Box 6	that the death certifical led by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mon⊎s? 1 ☐ Yes 2 1 ☐ Yoo 9 ☐ Unknown	c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3 ☐	Ectopic pregnancy	/		23d. Date of delive	ery Day Year		
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to the	./.		
or Vital Record	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform 1∐ Yes 2	prior to co	psy findings available mpletion of cause of 2 Mo		
Division or Vita	Attending Physician: The releath. ector: Atter this certificate by the funeral director, pag	Certification: To Be	27. Mann f Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Worl M 1 🗍	er: 4□ Nursing	28d. Describe how	nce 6 Hother (Spech w injury occurred	OSPICE		
Divi	i Pitte	Sertifi	4 Homicide determined	Zer. Location (Street and Number of Aural Houte Number)								
	To the Hospital within 24 hours of To the Funeral completely filled	edical (cian: To the best of my kno er: On the basis of examina and manner stated.								
2	To the within 24 To the l	Ž	29b. Signature and title of certifier	ingh ,	M.D	29c. Licens	e number (416	$0 \int_{0}^{29}$	d. Date signed (Month,	Day, Year)		
_	0		30. Name and address of person who con	11 MD 52	110 H	RITCHIE	= HLUX	BALT	o md	21225		
	Sta Registi		31. Date filed (Month, Day, Year) 3 2008	Registrar's Signa	ature	R.		,				
DH	MH 17 Rev 1/2	John Committee C										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 9:24PM MACKAY WILLIAM June , 2008 25 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A Memorial Hospital Baltimore Union 8. Date of Birth (Month, Day, Year)
Sent. 18,1932 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days Months Hours 1 M 2 □ F Michigan 75 315-30-2956 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 No Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21201 U.S.A. 524 N. Charles Street Apt. 1610 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Dance Brothers Cont. Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth SAvage S. Mackay Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 325 Orchard Avenue, Baltimore, Maryland 21225 <u>Kristin R. Channels (Daughter)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsyille VA Cem 07-01-08 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 237 East Patapsco Avenue
McCully-Polyniak Funeral Home P.A.Balto, Md 21225 21. Signature of Fune 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ir coediate Cause (Final obstructive nulmonary years resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 5 ☐ Other (specify) g 🗌 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventines must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

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Completed

Be

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Examine

attending physician and for use as the burial-transit Physician/Medical icate has been signed by the page 2 should be detached <u>چ</u> Completed After this certificate funeral director, pag-Be Certification: To n 24 hours after death.

e Funeral Director: A letely filled in by the fu death.

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

within 2 State 23b. Was decedent pregnant

6 Could not be determined

25. Was case referred to medical

1 ☐ Yes 2 No

27. Manner of Death

1 Natural
2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

JUL

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

performe

1 ☐Yes 2 🗷 No

1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

AT2438946-A5

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Memorial Hospital burg Latt MD 0 3 2008 31. Date filed (Month, Day, 2. Registrar's Signature

Glen Burnie, Maryland Approximate Interval Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 28f. Location (Street and Number or Rural Route Number, City or Town, State) & Baltimore Annapolis
Route 2 at Whitee Read, Arnold, MD B₁v_d 29a. Certifier 1 (Check only one) 2 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number June 27, 2008 O.C.M.E. 30. Name and address of part in who completed cause of death (Item 23a) 10 111 Penn Street, Baltimore, MD 21201 Russ Alexander MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 3 2008 istrar's Signatu State Registra DHMH 17 Rev 1/2001 **ORIGINAL** OCME **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4:00 PM Robert Melton, Jr. 2008 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Balkinona ARSON Hurrital N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 11 M 2 □ F 434-42-3340 78 Director 7,1930 Louisiana Πan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or item 23 a or 28a-f show 10c. City, Town or Location 10a. State 10b. County a or 28a-f show t be notified at 10d. Inside City Limits Baltimore Maryland N/A 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 2811 Quantico Avenue ms 23a Funeral 'natural', or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 DXYes 2 No 1951 If Yes, Give Year or Dates: 1953 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: ģ 3 Widowed 4 Divorced Completed the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Millennium Inorganic alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Packer Chemicals 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucinda Robert Melton, ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2305 Birch Drive Baltimore, Maryland 21207 19a. Informant's Name/Relationship (Type. Print) Monica Melton/ Daughter item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/7/08 • Cem• 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department or Important: If any Injury or once. = 5 Owings Mills, Md Garrison Forest Vet. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liven ee 22. Name and Address of FacilityChatman-Harris Funeral 5240 Reisterstown Road Baltimore, Md 21215 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIN macdinte /Medical Due to (or as a consequence of): Examiner YEARS (0,20; AA) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760-Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. 9□Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cate has been significant categories, page 2 should b 1 Tes 2 No 3 Probably 4 Donknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 2 No Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ✓Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie BUKOVITZ MD D0061435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ANDREW

JUL 0 3 2008

31. Date filed (Month, Day, Year)

3001

01:12

2. Registrar's Signature

MD

South Hangver St. Baltimore MD 21225

State of Maryland / Department of Health and Mental Hygiene 2008 21548 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 1, Marion T. Malick 2008 13:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 39 Chelmsford Court Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2√2√F Director 213-36-0490 70 10/07/1937 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Medical Exercines coust to notified at 1 ☐ Yes 247XNo Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6817 South River Drive 21220 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beckton-Dickinson Assembly Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 Is marked or any injury or other traumatic eve once. Alexander Trout Edna Martin ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathan Malick (Husband) 6817 South River Drive, Baltimore, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 4 ☐ Donation 5 ☐ Other (Specify) 07/05/2008 | Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility.

Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final disea a or condition resulting in death) **Physician** Irterio sclerotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed burial-trans and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical ding p IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery atten for us The law requires that the death Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a P.O. 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ 1 XYes 2 No 3 Probably 4 Unknown as been si 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy page perform 1 ☐ Yes 2 🖾 No 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence ည 1 XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 29a, Certifier 1 💆 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 0 D0036343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WANDA WICKS CAMPBELL BLVD 4920 WHITE MARSH 31. Date filed (Month, Day, Year)

State

Registrar

32 Registrar's Signature

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** NNIE M 50 PM 07 2008 () /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE MANOR CARE-ROLAND PARK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Min. Director 80 216-20-3472 17 1928 NORTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ms 23a or 28a-f shore Director 1X Yes 2 □ No MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 U.S.A. 1233 N CENTRAL AVENUE Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Wedical Evan in the reasons. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify. Š Specify: BLACK 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LIFE LIKE PRODUCTS FACTORY WORKER llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ BERTHA BARCO JNO WILKINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1233 N. Central Ave., Baltimore, Maryland 21202 Romaine C. Hargrove/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL PARK 07-07-08 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Louis WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Michaga 10 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2treiner /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the detached g | Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Urrsing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician: filled in by the funeral director, 24 hours after death. ■ Funeral Director: A within 2

the Maryland

death with

Baltimore, Maryland 21215-0036

State Registrar

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31. Date filed (Month, Day, Year)

29a, Certifier

(Check only one)

29b. Signature and title of certifier

CENTER DRIVE REISTERSTOWN MD 21136 BUSINESS

and manner stated.

M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DU059107

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Joan Frances McCartin 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death M O If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F 78 Yrs. Director 038-20-6670 Usual Residence of Decedent 12-21-1929 Rhode Island Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturai", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 27 ☐ No Director Md. Balto.Co. Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Kings Glen Ct. 21087 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: White 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced Specify. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Group Chief Operator Phone Company 12th Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ John A. Young Ethel Moses 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Kings Glen Ct. Kingsville, Md. 21087 Patricia Sibiski DTR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sarasota Memorial Park 7-8-2008 Florida 21. Signature of Fu 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Esquentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a. Was an has autopsy performed death? 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 🗆 🗘 1 Inpatient ပ 2 ER/Outpatient 3□ DOA 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide The rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Wedical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

OD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lanue

31. Date filed (Month, Day, Year)

0 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** asters Jul 2008 11:5 /Medical 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examine INS Bayview Medical Center Hopk Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Maryland **Funeral** 1□ M 2□ F Months Days Hours Min Director 83 Feb. 28,1925 212-22-9587 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marked of the traumatic event, If a Marked Examine Injury to other traumatic event, If a Marked Examine Injury or other traumatic event, If a Marked Examine Injury or other traumatic event, If a Marked Examine Injury or other traumatic event, If a Marked Examine Injury or other traumatic event, If a Marked Examine Injury or other traumatic event, If a Marked Examine Injury or other traumatic event, If a Marked Examine Injury or other traumatic event, If a Marked Examine Injury or other Injury or o 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 ☐ Yes 2 ☐ Xio 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 U.S.A. 1941 Ewald Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify ۾ 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William G. Rodgers ပ Mary A. Dailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1941 Ewald Avenue Baltimore, Maryland 21222 Mrs. Mary Davis/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 7/7/08 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dulmonary WEEK edema /Medical Due to (or as a consequence of) Examiner ischemic cardiomyopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical as use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed cate has been g 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? 1 Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifies Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 Sischle

State Registrar

DHMH 17 Rev 1/2001

Ave B. I.N Room 108A, Baltimore MDZIZZA

4940 Eastern

32. Registrar's Signature

30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print)

Emily Deschl

e filed (Month, Day, Year)

ことみなる Mynns Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinat must be notified at once.	2	W 19a. Informant's N		Hambleton		10	h Mailin	ig Address (Stre	at and M		t Ann H			Zin Code)	
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Department any once) Signal e of t	2 '	Licanisae .	a 1	00	22	Name and Add Duda-Rud 7922 Wi	ck Fu	uneral Ave. I	Home o	f Dui	ndalk, 21222	Inc.	
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ital or its after al Direction in its	Certi	4 Homicide	determi	build build	ling, etc. (S	Specify)					City or Tov	vn, State)		ia/a//ioaro	vaboi,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the I	Medical	29a. Certifier (Check only one)	1 ☐ Certifyin 2 ☐ Medical	g Physician: To the Examiner: On the I	e best of m basis of exa ner stated	amination a	je, death nd/or inv	occurred at the restigation, in my	time, dat opinion,	te and place, death occurr	and due to the ed at the time,	cause(s) date and	and manner and du	as stated. le to the cau	se(s)
To the within To the comple	Med	29b. Signature and	title of cortifier	andmai	iller stated			29c. Lice				29d. Date	e signed (Mor	nth, Day, Yea	ir)
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5		30. Name and address	()	VC0 2	15 M	MAIS	THE	7-T 11	1571	n Tran	N/ M/				
Sta		31. Date filed (Mont	th, Day, Year)	32.	egistrar's		e · ca	مع .	, 13/6	JLSE OVV	A 1-CO				
Registr	ar	J	UL 03	2008	MENNE	DE	A	en l							

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** М June 29 2008 William Colvin Mason a. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Summit Park Nursing Home Baltimore Catonsville 8. Date of Birth (Month, Day, Year)
JUL 21 1924 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 X M 2 □ F Months 83 216-16-4467 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Howard Woodstock 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 2100-G1 Ganton Green 21163 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 ∐Yes 2**X**If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Model Maker 10 Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur R. Mason Unk ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum Joyce R. Mason - wife 2100-G1 Ganton Green, Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem Gdns. 7/2/2008 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 21. Signature of Funeral Service Licensee. Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Road, Catonsville, MD Williams 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** jas Y~1 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and stransit the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ed by the g 1 □ Yes 2 □ No. Ö 9 Unknown σ. cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 3 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? certificate I 1 ☐ Yes 2 ☐ No Physician: : After this certification of the thick of t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Matural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egist/ar's Signature 31. Date filed (Month. State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Frances M. Nelson 2000 tune /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 1, 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland 1 ☐ M 2 😿 F 1922 86 218-14-6399 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Glen Burnie Director MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 USA 1 South Park Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Injury or other traumatic event, the homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard J. Doniecki Eva Andryszak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10850 Green Mountain Circle #607 Columbia,MD 21044 Kathy Verheul/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Baltimore, MD 21201

23a. Part. E ter the disease, one implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronany /Medical Due to (or as a consequence of): Examiner attenschooli solese Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autonsy perform 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ After this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending within 24 hours aries are.

To the Funeral Director: Aft 1 🗌 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28. Name and address of person who completed cause of death (tem 23a) (Type, Print) Molty Oke Tung 31. Date filed (Month, Day, Year) State 3 2008 0 Registrar

Medical Examiner

Funeral

Director

s 23a or 28a-f show e notified at once.

event, the Medical Examiner

item 27 is mir r traumatic e

or other

Director

Funeral

3

Completed

12

death with the Maryland

Physician/

Registrar

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21555 Certificate of Death 1- For State Reg. No 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day June 22, 2008 1230 hrs Stephen John Owen 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 219 Willow Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday Foreign Country) MD 5. Social Security Number 6. Sex Months Hours Davs 06/03/1961 1 X M 2 47 213-84-1442 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No Towson Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21286 219 Willow Ave. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married Yes f Yes, Give Year 1988-91 Yes 2 X No specify: Specify: White Divorce Widowed 6b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Retail Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bonnie Westemeyer John Leonard Owen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ccde) 19a. Informant's Name/Relationship (Type, Print) 219 Willow Ave. Baltimore, MD 21286 Bonnie Westemeyer / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory June 24, 2008 Beltsville, MD 4 Donation 5 Other Specify. AFA/ Stephen D. Lohrmann, P.A. 21. Signature of Funeral Service Licensee B717 Green Pastures Dr. Baltimore, Lynda Sue Ritter-M01443 per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line Death Blunt force chest trauma Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last AMENDED 23a,PII,27,28a-f perME,g881 7/9/08 TT 21 per FD G881, 7/3/08 TT X UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Unknown 23e. Did tobacco use contribute to the cause of death?

Physician Wedical aminer

Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "

Examine and transit Physician/Medical ing physician a as the burial signed by the attending be detached for use as t è Completed has been s certificate h this certifial director, After th funeral o Funeral Director: tely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Box 68760,

P.O.

Records,

Division of Vital

Be ۵

Certification: 3 Medical

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CHronic alcohol abuse with cirrhosis of the 24a. Was an autopsy liver performed? ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medica Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: 1 examiner? FR/Outpatient 3 Inpatient 2 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Yes 2 X No subject fell 1 Natural Pending Fnd 6/22/08 Fnd 12:18 Investigation 28f. Location (Street and Number or Rural Route Number, City 2X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 219 WIllow Ave Towson, MD Could not be Suicide residence (Specify) Homicid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

To the

Russ Alexander MD.

29b. Signature and title of certifie

ne and address

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner . Registrar's Signature

who completed cause of death (Item 23a)

ÖRIGINAL

29c. License number

O.C.M.E.

DOME

24b. Were autopsy findings available

death? 1 🗸 Yes

29d. Date signed (Month, Day, Year)

June 23, 2008

prior to completion of cause of

2 No

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 21556 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 11.58 AM 1-1 2008 ul 151 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner genus Howard County Howard Howard Co. Hospital hop Pi General If Under 1 Year | If Under 24 Hrs. Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F Months Hours Min. Director 216-34-2924 December 25.1936 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD NABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 6509 Woodgreen Cir. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>Ş</u> Specify: Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>12th grade</u> 2yrs Clerk Typist MD Realtors Comm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde M. Johnson Jessie M. Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Michael B. Woolridge-Son 6509 Woodgreen Cir. Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once. Memorial Park 7/9/08 Randallstown, 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
March F/H West Part1. Enter the disease, or complications that caused the death. Do not inter the mode of dying, such as cardiac or respirating arrest, or ediate Cause (Final 21215 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No 4☐Pregnant at time of death 9☐Unknown Year Month Day 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**2** No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 5 Pending investigation Injury 1 Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MD 61343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HE 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

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			For State Registrar	State of I	Maryland		artment of F		Mental Hy	giene , Reg. No.	2008	21557
	Dhoois		1. Decedent's Name (First, Middle	e, Last)					2. Date of De	ath		3. Time of Death
	Physic /Medi		WILLIAM		PE	CK			JULY	Day	2008 Year	11:55 A.M
. Age	Exami	ner	4a. Facility Name (If not institution		er)		4b. City, Town, or	Location of Dea	th	4c. C	ounty of Death	
47	Funeral	۳	740 CAMBERLEY 5. Social Security Number		Age (In yrs. las	t hirthday)	TOW If Under 1 Year	SON If Under 24 Hrs	I D Date of Di	41.	BALTIMO	
	Director		029-14-9919	1 X M 2 □ F	82	Yrs.	Months Days	Hours Min	(Month, Da	ay, Year)	Coul	place (State or Foreign ntry)
	pu ,		Usual Residence of Decedent						7/7/19	225	MA	
	shov	5	10a. State 10b. County MD BALT	MODE	10c. City, 1						1	0d. Inside City Limits
	the N	Director	MD BALTI 10e. Street and Number	MORE	1	OWSON						1 ☐ Yes 2 No
	3a or	Ö					10f. Zip Code			10g. Citize	n of What Cour	ntry?
	death	Funeral	740 CAMBERLEY (12. Was Deceder	nt Ever in U.S.	13. V	2120 Vas Decedent of Hi f Yes, specify Cuba) 4 spanic Origin? (5	Specify Yes or No	14	JSA . Race - Americ	can Indian
92	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Model Examinat must be notifyed at	y Fu	1 ☐ Never Married 2 ☐ Marri	Armed Force ed 1 XYes 2 [If Yes, Give					to Rican, etc.)		Black, White,	
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Ċ	in 72 n "nat	Completed	15. Decedent (Specify only highes	t grade completed)	1	(Give	lent's Usual Occupa kind of work done o DO NOT use retired	uring most of wo.	rking	16b. Kind	of Business/Inc	dustry
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		BeC	17. Father's Name (First, Middle, L			DOI	VD ONDERW.		me (First, Middle,			
<u> a</u>	should be nd Menta marked maric ev	2	WILLIAM PECK	_				DORA	LABONTE	C		
Mar	2 sho and is m		19a. Informant's Name/Relationsh	ip (Type. Print)			g Address (Street a					Code)
ອ໌ ອ໌	t and Health Sm 27 ther t		CATHERINE TAMBU	RRO/DAUGHTI		83 W	OODBERRY	HILL DR	· SOUTHI	NGTON	, CT C	6489
0	ages nt of t: If its		20a. Method of Disposition 1 X Burial 2 Cremation	3 ☐ Removal from Stat	Ç		sition (Name of natory or other place	9) 7/5/	Date		tion - City or To	
ашт	nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		MT.		ENEDICT	7/5/	- 1		FIELD,	
Ö	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic every	1	21. Signature of material Service E	censee			Name and Addres 3521 LOCH			ON FUN OWSON,		DME, P.A. 1286
			23a. Part 1. Enter the disease, or o	omplications that cause	ed the death. [MD &	Approximate Interval Between
· F	hysician		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each	line.		IARY					Interval Between Onset and Death
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequent	ce of):						
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5	icate be executed physician and the burial-transit	dical		d.								
		Medi	IF FEMALE:									
	nie aw requires that the death centri ate has been signed by the attending age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e of pregnancy 2 Fetal dea		Ectopic pregnancy			230	d. Date of delive	ry
5	by the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death		Other (specify)				Month	Day Year
	ned by detac		Part II. Other significant condition	s contributing to death	hut not resulting	n in the unr	terlying cause giver	in Part I	23a Did to	bacca uca	contribute to the	e cause of death?
3	n sign	d by		,		y a	Johnymig Sausse giver	, III I GI (1,	1 □ Y			
	s peen s	leted							-			· A
94	cate has	ompl			11				24a. Was a autop perfor	sy med?	prior to con death?	osy findings available npletion of cause of
		Be C	25. Was case referred to medical					26 Place of Dea	1 □ Yes th (Check only oi	No No	1 □ Yes	2 □ No
Attending Dhysiolen:	this ce	2	examiner?	Hospital: 1 ☐ Inpat	ient 2 🗆 ER/	Outpatient	Otto		8 -	,	Other (Specify	")
	h. After thi funeral	ö	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D		. Time of Injury	28c. Injury Work?		28d. Describe h			,
1	death tor: / the f	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	he			M 1 □ Ye	es 2□No				
	after Direc	Certification:	4 Homicide determine	28e. Place of in	jury - At home, tc. <i>(Specity)</i>	farm, stree	et, factory, office		28f. Location (S City or Tow	treet and N n, State)	umber or Rural	Route Number,
snifa	neral fillec		29a. Certifier Certifying	Physician: To the best	of my knowled	lge, death	occurred at the time	data and place	and due to the	20160/s) an	d manner og et	atad
To the Hosnital or	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Ex	aminer: On the basis and manner s	Ji examination	and/or inve	estigation, in my opi	nion, death occu	rred at the time, o	date and pla	ice, and due to	the cause(s)
To T	To the community	ž	29b. Signature and title of certifier	7 1 12.	T ()		29c. License	number			gned (Month, E	Day, Year)
			16e041/	Lacion	111)			732	>	7/1	108	
L	ft1	ſ	30. Name and address of person wh	EDDN 8	leath (Item 23a	(Type Pr			SA-12.	1/2	DI.	21204
	State	0	31. Date filed (Month, Day, Year)		rar's Signature	101	1. Cu	aures	81.170	ITU	1101-6	21204
	* Registra	٠ .	JUL 0 3 200	20	K	hast.	,					
			V ba	1-000	10	200						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008 21558 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Day Year aritz 08 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Janupolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 23, Birthplace (State or Foreign Country)
 Cuba 7. Age (In yrs. last birthday, Days 583-07-6187 1 □ M 2 🔀 F 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Guaynabo Guaynabo, Puerto Rico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? # 11 Palma Real 00966 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 XYes 2 ☐ No Specify: Cuban Specify: White 3 Widowed 4 ☐ Divorced

within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Iran Medical Evantment in ust be notified as any injury or other traumatic event, Iran Medical Evantment in ust be notified as agree. Baltimore, Maryland 21215-0036

Physician

/Medical

Director

Funeral

Examiner

Funeral

Director

Physician /Medical **Examiner**

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Be Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's U	sual Occupation work done during mos use retired)	16b. F	16b. Kind of Business/Industry				
Jmp	Elementary/Secondary (0-12)	College (1-4or 5+)		ruse retired) Crative Ass			Constru	ction		
ပိ	17. Father's Name (First, Middle, Last)				er's Name (First, Mic	idle, Maidei				
To B	Aurelio Piedra			Ma	aria Corvi	son				
_	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailing Addr	ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	Gloria McGough, I	Daughter Daughter	203 Blac	k Skimmer	Court Edg	gewate	er, MD 2	1037		
	20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □	Removal from State	Place of Disposition (Interpretation of Place of Disposition (Interpretation of Place of Place of Place of Place of Place of Disposition (Interpretation of Place of Place of Disposition (Interpretation of Place of Disposition of Place of Disposition of Place of Disposition (Interpretation of Place of Disposition of Di	Vame of or other place)	Date	20c. L	ocation - City or	Town, State		
	4 ☐ Donation 5 ☐ Other (Specify) Met	ro Cremato	ory Inc.	07/02/08	Bal	timore,	Maryland		
ŀ	21. Signature of Funeral Service Licental Thomas Gregor	ty		and Address of Facility ation Soci Frederick	ety Of Ma Road Balt	arylan imore	d, Inc Maryl	and 21228		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	n. Do not enter the n	node of dying, such as	cardiac or respirato	ry arrest,	9	Approximate Interval Between Onset and Death		
	disease or condition resulting in death)	a. Oue to (or as a consequence)		Sensit				48 home		
er	Sequentially list conditions, if my local conditions cause. Enter Underlying	b. Cholang;	tis					48 hour		
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Ductellin	12					48 hans		
ical Ex	resulting in death) Last	d. My lody	pence of):					1412r		
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	I death 3 Ectopi	c pregnancy (specify)			23d. Date of de Month	livery . Day Year		
y Ph	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the underlyin	g cause given in Part I.	23e. D	oid tobacco	use contribute to	the cause of death?		
ed b	Aute 1874 Failus	· e			1	☐ Yes 2	No 3□ P	robably 4 🗌 Unknown		
Complet					—— l a	Vas an utopsy erformed?	prior to death?	utopsy findings available completion of cause of		
Be	25. Was case referred to medical examiner?				of Death (Check or	nly one)				
0	ILI 165 Z DAINO		ER/Outpatient 3		rsing Home 5 🗆 F			ecify)		
ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		be how inju	ry occurred			
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, street, fact	ory, office	28f. Location City or	on (Street a Town, State	nd Number or R e)	ural Route Number,		
edical		sician: To the best of my kno iner: On the basis of examina and manner stated.								
Ž	29b. Signature and title of certifier	/		29c. License number		29d. Date signed (Month, Day, Year)				
	M-/ 7/	MO		064089		Ju	July 1, 2008			
	30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, Print)							

ORIGINAL

Medical Parkary Angpolis MD

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State Registrar

Sanc

Mark

31. Date filed (Month, Day, Year)

JUL 0 3 2008

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 21559 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Margaret Mary Peterson JUNE 29. 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Examiner Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex **Funeral** Min. Hours Months Days 1 □ M 2 🛛 F 95 078-14-1766 02-07-1913 Canada Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural" — any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 ☐ No Director Baltimore City MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 U.S.A. 1601 E. Belvedere Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates Specify Completed by Specify. White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Murphy John Tobin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11166 Bluff Creek Cr., Anchorage, AK Ingrid Parish / Granddaughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Towson, Maryland Hilltop Service Corp. 7/1/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. meral Service Licensee 21. Signature of 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death bo not enter the mode of dying, such as cardiac or respiratory arrest, nmediate Cause (Final **Physician** ADVANCED CRITICAL AORTIC STENOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettendin for use a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ANo 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed Ves 2 No 2 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/ar invastication in the cause (s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check d one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a D 53593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHRAF S. OSLER DRIVE TOWSON MARYLAND 21204 MOSTAFRAM. D. 7601 31. Date filed (Month, Day, Year) State JUL 03 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** John Ρ. Rinker July 1 2008 8:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Co. Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Months 1⊠M 2□ F Yrs Director June 3, 1934 | Maryland 213-32-5766 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be netitied at 1 □Yes 2 No Director Dundalk Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 21222 1911 Dineen Drive United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 9 Years Steelworker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella M. Murray Lee P. Rinker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other training. Dundalk, Maryland 21222 1911 Dineen Drive Mrs. Joanne T. Rinker (Wife) Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Dopation 🔊 ☐ Other (Specify) 3 Removal from State Hilltop Service Corp. 7/5/2008 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician astrointestmal disease or condition resulting in death) /Medical the to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit be executed and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ned by the a P.O. 9 I Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐Yes 2 ☐ No 1 TYes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Her (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this re Hospital or Attending Pl n 24 hours after death. re Funeral Director: After the 27. Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical e Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LES ST POWSON MO ZIZOY 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 03 Registra

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		For State Registrar		State of	iviai yiai i		tificate of L		ivieniai ny	Reg. No.	2008	2156	-
Physicia	an	Decedent's Name (First, M		,					2. Date of De Month	Day	Year	3. Time of Death	
/Medic	al	George J. Rail 4a. Facility Name (If not institut			ner)		4b. City, Town, or	Location of Deat	June_	28	2008 County of Death	1:36 PM	_
Examin	er	Greater Balt				er	Towson				altimore		
Funeral		5. Social Security Number	6. S		Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		rth	O Pirth	place (State or Foreign ntry)	_
Director		219-22-8986 Usual Residence of Decedent		X	82	Yrs.			09-25	-1925	Mar	yland	_
ryland how at		10a. State 10b. Cou	•			ty, Town or Lo						10d. Inside City Limits	
ne Ma 8a-f s otified	ecto		timo	re	L	uthervi			T.			1 □ Yes 2 🛣 No	_
with the sa or 2 to be n	Funeral Director	10e. Street and Number 23 Bramleigh	Pon.	d			10f. Zip Code 21093			10g. Citiz	zen of What Cou		
death	nera	11. Marital Status	Noat	12. Was Deced	ent Ever in U	I.S. 13. V	Vas Decedent of His f Yes, specify Cuba	spanic Origin? (S	Specify Yes or No	0-	14. Race - Ameri Black, White	can Indian,	_
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Derartment of Hea th and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	by Fu	1 ☐ Never Married 2 💢 I 3 ☐ Widowed 4 ☐ Divor		1 X Yes 2 If Yes, Give Year or Date	□No	- 1	I ☐ Yes 2 🂢 No	Specify:	10 1 110411, 010.)		Specify: Whi		
72 hou natura IIcol E;	ted	15. Dece (Specify only hi	dent's Ed	ducation		16a. Deced	lent's Usual Occupa	ation Juring most of wa	rkina	16b. Kii	nd of Business/Ir		
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illed Hygid other ent,	Be Co	17. Father's Name (First, Mid	. ,			<u> Kac</u>	ing of the	18. Mother's Nar		, Maiden	Surname)	1119	_
Menta Menta arked artic ev	To B	George John	Ramr	m in g				Monica	Elizabe	eth M	liner		
d 2 shoth and 7 is m		19a. Informant's Name/Relat				1	g Address <i>(Street a</i> Bramleigl						
of Hearlitem		20a. Method of Disposition		· · ·		Place of Dispos	sition (Name of natory or other place	1	Date		cation - City or T		-
Page tment c tant: If tjury or		1 XBurial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	r (Specify	y)		rkwood	Cemetery	07-	03-2008	Balt	imore, I	Maryland	
pe mit Decar Impor any in		21. Signature of Fineral Sen	ice Licer	Lulle.	du	22	Name and Addres	·	Ruck Tov Towson,	wson Mary	Funeral land 2	Home, Inc. 1204	
		23a. Part1. Enter the disease shock, or heart failure.	, or com	plications that cau one cause on eac	sed the deat th line.	th. Do not ente	er the mode of dying	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a.	as a conseq	TIONOO OE):							_
Examiner	Ш			cell	. 1	3 3							
p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	7	Due to (or	as a conseq	quence of):							
execute n and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		cDue to (or	as a conseq	quence of):							
tificate be executed g physician and as the burial-transit	edical		l	⊾d									_
		IF FEMALE:		23c. If yes, outco	mo of progn	anov							-
death cert e attending d for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 □Live birl 4 □ Pregnai	th 2 ☐ Feta ntattime of o	aldeath 3 ⊑	Ectopic pregnancy Other <i>(specify)</i>			1	23d. Date of delive Month	pery Day Year	
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aw req	Completed								24a. Was		24b. Were aut	opsy findings available	_
sician; The law certificate has t irector, page 2 s	Som								peri 1 Yes	opsy ormed? 2 X No	death?	ompletion of cause of	
ysician; iis certific director,	Be	25. Was case referred to me examiner?	tical	Hospital:			t 3 DOA Othe	ar:	ath (Check only				
> 0 0	2	12 Yes 2 No 27. Manner of Death		28a. Date of	Injury	ER/Outpatien 28b. Time of	. 0000	4 🗀 Nursing r	Home 5 ☐ Res 28d. Describe		6 □Other (Spec y occurred	ify)	_
ath. or: Affe	atio	Z A Moordon	estigation	May 27,2	Day Year)	unkhou		<br Yes 2. ⊠ No	fa	11			
or Att	Certification:		uld not be termined	28e, Place 0	, etc. (Specia	fy)	eet, factory, office		City or To	own, State	23 Bran	ral Route Number,	
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the Ho in 24 I the Fu	Medical	one)		niner: On the bas and manne		ation and/or in	vestigation, in my o		urred at the time				_
To Son	2	29b. Signature and title of ce	tifier N	6 6	2.0		29c. License				te signed (Month		
124		30. Name and address of per	son who	completed cause	of death (Iter	m 23a) (Type	\>\ 86				15,20	08	_
10		Philip M	1:1:	ello, Mi) 6T	rimble	CT. Lutho	ru:lle,1	MG 210	93			
Sta Registr		31. Date filed (Month, Day, Y	ea <i>r)</i>		gistrar's Signa	ature	de	V					

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, <

1336 MS.

George J. Ramming Ju Baltimore, Maryland 21215-0036

June 28,2008

Amend Item 8 per fin, 9889 03/23/09dhb Health and Mental Hygiene Certificate of Death Reg. No. 2008 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY 2008 ELSIE A. ROMANOWSKI 8:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 😾 F 90 215-24-5694 MD Director 06/11/1918 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 ☑ No Director BALTIMORE MD TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 DULANEY VALLEY RD 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 21215-0036 1 ☐ Yes 2 No Specify 3X Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN BEAUTY SALON other other traumatic event. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 Is marked oth jury or other traumatic even Be JOSEPH PODGURSKI AMELIA KULINSKI 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT_ROMANOWSKI-SON BALTIMORE, MD 21122 102 BARHARBOR RD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ptrmit. Page D-partment o Important: If any Injury or ST. STANISLAUS CEM. 7/3/08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 21. Sign ure of Funeral Service Licensee POX BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part1. Hing the dise se, shock, heart failure. Lis Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, yone cause on each line. Immediate Cause Final Ameroscierone Conjoursentor Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-tran resulting in death) Last the death certificate be exe Due to (or as a consequence of) 68760 attending physician Physician/Medical as the Box (IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an director, page 2: autopsy performed? death? 1 ☐ Yes 2 ☐ No or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1/2 Natural 5 ☐ Pending Injury 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C Hospital 🛆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)43725 712108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 3 2008

A.M.

:45

2008

ROMANOWSKI

ELSIE

32 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUNE Year CHILLING 1110 AM 2008 4b, City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) 2000 SAMARITAN HOSPITAL BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours **1**√2M 2□ F 83 218-14-0009 11/20/1924 Balt., Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits Maryland Baltimore Baltimore 1X Yes 2 No 10g. Citizen of What Country? United States of America 10e. Street and Number 10f. Zip Code 3312 Echodale Avenue 21214 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2/3 No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) únk. plasterer construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ferdinand Schilling Katherine King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Defeo/Niece 8420 Harris Avenue Baltimore, Maryland 21234 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition July Date cemetery crematory or other place)
Lyans Funeral
Chapel Bel Air 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee Péaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 40 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition disease or condition resulting in death) Due to (or as a consequence of) ASTRO DINTE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Page A

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner πust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine

Baltimore.

Box 68760,

Vital Records, P.O.

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Director

Funeral

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Completed

death with the Maryland

The law requires that the death certificate be executed attending physician the as use ō the detached þ page 2 certificate this Hospital or Attending

Examiner Physician/Medical þ Completed Be Certification: To

completely filled in by the funeral director, After death. after death Director: within 24 hours a To the Funeral I

4 ☐ Homicide

29a, Certifier

Medical

State Registrar 1 🗌 Yes

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my existing death occurred.

Roven Boulevard 21239

29b. Signature and title of pertifier HYSICIAN

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of p is in all o completed cause of death (Item 23a) (Type, Print)

M.D. WIDS عرث ع

31. Date filed (Month, Day, Year) 3 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Month **Physician** elora 2 Tune /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARI-OR 0/2 Date of Birth (Month, Day, (In yrs. last birthday) If Under 1 Year **Funeral** Days Months Hours Min. 1 □ M 2 🗖 F Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wadical Examinar must be notithed at 1 ☐ Yes 2 No Director OREST 10e Street and Number 10f Zin Code 10g. Citizen of What Country's with 21057 Funeral death 1 Was Decedent Ever in MS Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married , or 215-0036 1 ☐ Yes 2 🗹 No Specify ģ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. 2 SIGA marked other Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Important: If Item 27 any injury or other tr once. eborah Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Pages 1 ₽ 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐ Removal from State permit. Page Department ALIT MORE, MIL Leine 22. Name and Address of FOREST MILLMD21050 21. Signature of Funeral Service L 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE RENAL DISEASE /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that in littated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ , page 2 should be 1 ☐ Yes 2 No 3 Probably 4X7 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an has certificate 1 ☐Yes 2X No Viital Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To o this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie UB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h 2300 DULANEY VALLEY RD. TARIO MAHMOOD TIMONIUM, MD 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 21- State of Maryland / Department of Health and Mental Hygiene 21- Registrar Regis 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2.35 PM JUNE Charles Surplis 8 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES BAITIMORE 8. Date of Birth (Month, Day, Year, DEC 24, 19 5. Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2□ F 74 517-32-8274 1933 Washington Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits than "natural", or Items 23a or 28a-f showns the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5919 Charnwood Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Maintenance Apartments parmit. Pages 1 and 2 should be filed v Department of Haalth and Mental Hygic Important: If Item 27 is marked other I any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Burt Surplis Vera Burnison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou Surplis/Wife 5919 Charnwood Rd Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State Metro Crematory, Inc | 6/13/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Home, P.A. 301 Frederick Rd Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac, r respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARBUNDIONIDE NARCOSIS cley **Physician** /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examine PAZUMON 16 burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Fibrilla from 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Ûnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No autopsy 1□ Yes 2XTNo funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Kres 20€ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

Division or

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

show

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Records,

Vital

physician

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certificate has

After this

filed within Hygiene.

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) JUL 0 2 2008

MATERN AWAN 10802 HICKORY RIDGE RD COLUMBIA 32. Registrar's Signature

MI

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Doc 62634

29d. Date signed (Month, Day, Year)

JUNE 8,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State 28 Maryland / Department 7/02/03/18 Mental Hygiene For State Registrar 2008 21566 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ichol 0340 AM u< June 26,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 67-37-**Funeral** Months Days Hours Min. 220-75-166 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits. 10c. City, Town or Location 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at talethorpe MI 1 ☐ Yes 2 No Director BaHimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? JSA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: 0 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Caucasian Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ronald E. Sco ellen ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington St. talethurpe, MDZJZZ,
20c. Location - City of Town, State Health in the sem 27 i Konall+Ellen Scottl 4312 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date Pages ' Important: If it any Injury or o 3 ☐ Removal from State BaHimure 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Grær 228 ndallstown, M0140 iner MD 21133 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** brain disease or condition resulting in death) /Medical Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner nding physician and use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: Box (23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy atten in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown P.O. the 9 Unknown been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No Yes certificate Division of Vital completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Inpatient Yes 2 🗆 No 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Subject in water over head in swimming pool.

281. Location (Street and Number or Rural Route Number, City or Town, State) 4312 Washington Street, Halethorpe, MD Fourkt p M **Netural** 06/21/2008 2 Ascident 1 ☐ Yes 2 X No death. after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 Suicide determined 4 Homicide Swimming Pool Hospital 24 hours 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) Within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ၉ 5 s of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Christopher Wa 31. Date filed (Month, Day, Year)

Watson

2008

DHMH 17 Rev 1/2001

0

600 North Wolfe St, Baltimore, MD, 21287

Johns Hopkins

32. Registrar's Signature

08-04	828
Mark	Southford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Mandand / Department of Health and Mental Hydiana

ark Southford		rtment of Health and Mental H tificate of Death	yglene 2008 2156
Physician/	Registrer 1. Decedent's Name (First, Middle,Last) Monday Charist tophory Courth Fond		2. Date of Death Month Day Year June 23, 2008 3. Time of Death 1145 hrs
F 1 Examine	Mark Christopher Southford 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	4900 Ritchie Highway 5. Social Security Number 6. Sex 7. Age (In yrs. la:	st birthday) If Under 1 Year If Under 24Hrs	Anne Arundel 8. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	212-98-1724 _{1XM 2} F 41	Yrs. Months Days Hours Min	■ IForeign
d d	MD Anne Arundel	Town or Location Jessup	10d. Inside City Limits 1 Yes 2 X No
with the Maryland ms 23a or 28a-f show be notified at ouce.	10e. Street and Number 7810 Clark Road #C 76	10f. Zip Code 20 7 94	10g. Citizen of What Country? United States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transitie event, the Medical Examiner must be notified at once.	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.: Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
urs after itural", aminer	3 N Widowed 4 Divorced in 1985, 3 No 1981	Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re	work done 16b. Kind of Business/Industry
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2121 uld be fi Mental I marked	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of	Rural Route Number, City or Town, State, Zip Code)
MD nd 2 sho afth and m 27 is aumati	Roselie Southford 20a. Method of Disposition 20b. 1	/810 Clark Rd., C#	76, Jessup, MD 20794 Date 20c. Location - City or Town, State
imore, Pages 1 a ment of He lant: If Ite	1 Burial 2 X Cremation 3 Removal from State 4 Constion 5 Other Specify: Wes	crematory or other place) t\ARundel Crematory 7-	1-2008 Odenton, MD brose Funeral Home, Inc.
Balt permit. Depart Import injury	21. Signiture of Funeral Service Licensee	1328 Sulphur Spri	ng Rd., Arbutus, MD 21227
Physician Medical (4	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.		Death
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o, e be execu ysician an burial - tr	X UNPENDED AMENDED 23a, 527, 28a-f.	, perME,G881 7/10/08	23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of d	2 Fetal death 3 Ectopic pre	Vees
). Boy the death by the att		resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
s, P.C nires that			1 Yes 2 No 3 Probably 4 ✓ Unknown 24a. Was an 24b. Were autopsy findings available
ecord: he law requate has been age 2 should			autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal R	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26.Place of Death (Che ER/Outpatient 3 DOA Other 4 Nu	rsing Home 5 Residence 6 🗸 Other: Scene
of Ving Physicites this neeral dis	27 Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Division of Vital Records, P.O. ria or Attending Physician: The law requires that the ris after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2.	1 Natural 5 Pending Investigation Suicide 6 X Could not be determined (Specify) Park	B Fnd 11:40 att. Yes 2X No home, farm, street, factory, office building, etc.	unk 28f. Location (Street and Number or Rural Route Number, City or Tawn, State) 4900 Ritchie Hwy S. Baltimore,
Division of Vital Records, P.O. But the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		Plaza Motel adge, death occurred at the time, date and place,	
To the within To the comple	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	29c. License number	29d. Date signed (Month, Day, Year)
	16.hours	O.C.M.E.	June 24, 2008
P	30. Name and address of person who completed cause of death (Ite Zabiullah Ali, M.D. Assistant Medical Examine	er 111 Penn Street, Baltimore, MD	21201
Sta Regist	A	H Again	
DHMH 17 Rev 1/20	July July July July July July July July	ORIGINAL	OCME

08-05046 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Janet Dawn Sands 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 30, 2008 1405 hrs Medical Examiner Janet Dawn Sands c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Pasadena 8118 Main Creek Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Country)Maryland Days Hours Min Months 02/07/1960 Director 2X F 48 219 82 1662 1 M Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 X No Pasadena s 23a or 28a-f show notified at once, Anne Arundel Maryland Director 10g, Citizen of What Country 10e. Street and Number 10f. Zip Code U.S.A. 21122 8118 Main Creek Road items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status permit. Pages I and 2 should be filed within 72 hours after death with Department of Health and Montal Hygiene. Important: I fiem 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes White Yes 2 X No specify: Widowed 4 X Divorced f Yes, Give Year ⋧ 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Hotel 21215-0036 Bookkeeper 10th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Jenkins Clifford Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Severn, Maryland 21144 659 Stags Leap Court Stephenie Scott / Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, Burial 2 X Cremation 3 crematory or other place) 07/02/2008 Baltimore, Maryland Bayview Crematory Donation 5 Other Specify 22. Name and Address of Facility Once unera ervice, .A. 21. Signa of Fineral Service 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part I. Enter the disease, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Meclizine intoxication complicating hypertensive Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): cardiovascular disease Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical X UNPENDED e attending physician a for use as the burial -AMENDED 23a, 27, 28a-f perME, g881 7/9/08 TT Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown 9 Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 ✔ Unknown Completed has been si 2 should b 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? 2 No Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Hospital: 1 Inpatient Nursing Home 5 Residence 6 ✔ Other: Scene 2 ER/Outpatient 3 DOA this 1 V Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 28b. Time of Injury 27. Manner of Death Certification: 1 Yes 2X No Natural Pending Director: d in by the f Fnd 6/30/08 FNd 2:05 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8118 Main Creek Rd Pasadena, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide single family residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 1, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD

OCME 2006

Registrar

31. Date filed (Month Day, Year 1008

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32. Registrar's Sie

			1 - For Stata Registrar	State of Marylar	nd / Depa <i>Cer</i>	rtment of tificate of	Health and Death	Mental Hygie		21569
	Physici		1. Decedent's Name (First, Middle, Last	anusi				2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, given		lati	4b. City, Town,	or Location of Deal	1	4c. County of Deat	0
	Funeral Director				(ast birthday)	If Under 1 Yea Months Days		(Month, Day, Y	9. Birt 2008	hplace (State or Foreign nuntry)
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Prince (reorges 10c. ci	ty, Town or Loc	N				10d. Inside City Limits 1 ☐ Yes 🌠 No
	ath with the 23a or 28 ust be not	ral Director	10e. Street and Number	Drive		10f. Zip Code 2 (720			States
920	72 hours after death with the Maryland naturel', or Items 23a or 28e-f ehow dical Exactinat roual be notified at	by Funeral	11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	If	/as Decedent of Yes, specify Cu ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
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ore, Mary	ss 1 and 2 sh of Health and item 27 is m r other traum		19a. Informant's Name/Relationship (1) Ad Ed Id Fayomi 20a. Method of Disposition 1 Burial 2 Cremation 3 D	/mother	1100		at and Number or Ri	ural Route Number, C	ity or Town, State, 2	Zip Code) 20720
Baltimore,	permit. Page Department of importent; if any injury or once.		4 Donation 5 Other (Specify 21. Signatury on Fungal 9 pices Licen	P	Set Set	y Boar Nate and Add altimore	ton yac Boar	rd 655 W. 1	Baltimore	Street
E	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immedia. Cause (Final disease or condition	Dications that caused the deal one cause on each line.						Approximate Interval Between Onset and Death
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. Box 6	death certif e ettending ad for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 🔲	Ectopic pregnani Other (specify)	су		23d. Date of del Month	ivery Day Year 2308
	w requires thet been signed t should be deta	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the un	derlying cause g	iven in Part I.	23e. Did tobac	.1	the cause of death?
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ZĬ.	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes \(2 \sum \) No	Hospital: 1 Inpatient 2 □	ER/Outpatient	3[] DOA C	thor	ath (Check only one)	- C []Oh (C	
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	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Criffier 1 ✓ Certifying Phy (Check only one) 1 ✓ Certifying Phy 2 ☐ Medical Exam	ysician: To be best of my kno liner: On the basis of examina and manuer stated.	owledge, death ation and/or inve	occurred at the testigation, in my	time, date and place opinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To the within To the Comp	Me	29b. Signature and title of certifier	MAL.	MA	29c. Licer	D357	8Y 29d.	Date signed (Mont.	h, Day, Year)
			30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, P	rint)	ean (2. Huna	lley	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 3 200	A. Registrar's Signa	ature	K)	60 (m)	olute.	100 KKI	7

08-04497
Crystal Straley
Physic
Medical Evan

stal Stral	ey	1	- For State	State	of Maryla	and / Depa <i>Cer</i>	rtment of tificate of		and	wenta	я нуд		eg. No.	200	8	21	57
Phy	sicia	_	Registrar 1. Decedent's Name (F	First, Middle,Las	t)			-				Date of Dea Month		Year		e of Death	h
edical Ex	amir		Crystal 4a. Facility Name (if no	Straley	o otroot and nu	imber)	I ₂	b. City, Tov	vn or i o	ocation of		June 11, 2	2008	County of Deat		47 hrs	
4			4a. Facility Name (if no 1024 Fairgrou			illiber)		Salisbu		, oation o				comico			
Fune			5. Social Security Num	nberunk 6. Se	ex	7. Age (In yrs. la	ast birthday)	If Under	$\overline{}$	If Under Hours	24Hrs.	8. Date of Bir	th(MM/DI	D/YYYY) 9. Bi Fore	gn	(State or	unk
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	items 23 ust be no	Funeral	11. Marital Status 1 Never Married	unk 2 Married		cedent Ever in U	.S. 13. Wa	s Decedent es, specify	of Hispa Cuban,	anic Origi Mexican,	n? (Spec Puerto Ri	cify Yes or No ican, etc.)	0- 1	4. Race - Ame White, etc.	erican Ind	ian, Blac	k,
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21 Should	is man		19a. Informant's Nam O.C.M.E.		Гуре, Print)		117							y or Town, Sta	te, Zip C	ode)	
Baltimore, MD Dermit. Pages 1 and 2 sh Department of Health and	item 27 traum	-	20a. Method of Dispo				Place of Dispos	ition (Name				more, Date		21201 ocation - City	or Town,	State	
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altir rmit. F	inry or	İ	21. Signatur of Fune	ral Service U e		Director	2 g ł	Vame and A	ddress Ma't	of Facility	Board	1 655	W. Ba	altimor	e St	reet	
		_	23a. Part I. Enter the	dispass or com	oltrations that	caused the death	Ba Do not enter t	altimo	ore.	MD such as ca	2120 ardiac or) 1 respiratory a	rrest, shoo	ck, or heart	Apr	roximate	interval
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OX 68 ath certi	e attending phy for use as the	Physician/IV	past 12 months?	o g 🗸 Unknow	4 Preg	nant at time of d		ther (Spec	ify)								
a	by th		Part II. Other signifi		3 UNK	nown to death but not	resulting in the	underlying	cause g	iven in Pa	art I.	23e. Did	tobacco	use contribute	to the c	ause of d	eath?
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ital sician:	w =	Be	25. Was case referre examiner?		Hospital:	Inpatient 2	ER/Outpatier			of Death Other		Home 5	Reside	ence 6 🗸 O	ther: Sce	ne	1,
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Di ospital o	meral Direc y filled in by		4 Homicide	determin	ed (Specif	est of my knowle	dan danih an	urrad at the	time de	ate and al	ace and			od manner as	stated.	-	
thin 24	To the Funeral completely filled	Medical	(Check only one) 2	Certifying Physi Medical Examin	er:On the basi and manner	s of examination	and/or investig	ation, in my	opinion	, death or	ccurred a	t the time, da	ite and pla	ace, and due t	o the cau	ıse(s)	
Ĕ B	F 8	Me	29b. Signature and t	itle of certifier	and manner	olatoa.		290		e number		CME		Date signed)ay,Year))
			Thron	lu Ml	Krog	Thyan	-p		O.C.	WI.⊏.			Jun	ne 12, 2008			
		, i	30. Name and addre Theodore M.			use of death (Ite tant Medical		111 Pe	nn St	reet, Ba	altimore	e, MD 212	201				
	s	tate	31. Date filed (Month	h. Day Year) 21	108 33	Registrar's Signa	The Ass	de									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown River Ken If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 11, 19 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F 1921 215-12-6485 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No MD Kent Chestertown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Greenwood Avenue 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 2 Yes 2 □ No If Yes, Give Year or Dates: 42–4 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or Ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 42-45 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) salesman insurance permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumath. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Allan Schlenker Katherine Marie Dahl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Greenwood Avenue Chestertown, MD 21620 Leah Schlenker/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 □ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Sort S. Wade Director Baltimore, MĎ 21201 Approximate Interval Between Onset and Death Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ownear failure? List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alzhoiners Marys /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 🗆 Yes 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3□ DOA 4A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 | Pending 1 Yes 2 No investigation 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0050996

Neil Staddard 31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 100 Brown St

Chestertown MID

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan		rtificate of	Death	R	leg. No. 2008			
Physic /Medi			Decedent's Name (First, Middle, Last) MARTIN		STERN			2. Date of Dea Month JM6	th Day Year 3011 200	3. Time of Death 8 6:45 A M		
	Examin	ner	4a. Facility Name (If not institution, gire SEASONS HOSPICE @	NORTHWEST HOS	RTHWEST HOSPITAL RANDALLSTOW		NDALLSTOWN		4c. County of Dea	RE		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a sary hipty or other traumatic event, the "Mardical Examiner must be notified at once.	To Be Completed by Funeral Director	213-10-2012	Sex 7. Age (In yrs. 1 Age) 83	last birthday) Yrs.	If Under 1 Year Months Days		B. Date of Birth (Month, Day 06/06/1	9. Bi	rthplace (State or Foreign ountry) MD		
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							1		
			MD BALTIMORE		BALTIMORE			1 □Yes 2 No				
			2 STONEHENGE CIRCLE, #7		10f. Zip Code 21208		1208	10g. Citizen of What Country? USA		ountry?		
Maryland 21215-0036			11. Marital Status 1 ☐ Never Married 2 👿 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:		1 □Yes 2 🖔 No	Hispanic Origin? (Spec ean, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	Specify.	te, etc. HITE		
			15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of working	7	16b. Kind of Business	s/Industry		
			Elementary/Secondary (0-12)	College (1-4or 5+)	OWN	ER	,		PIZZA S	НОР		
and			17. Father's Name (First, Middle, Last) ÅBE STERN			18. Mother's Name (First, Middle, BESSIE			Maiden Surname) GREENBLATT			
Baltimore, Maryla			19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	t and Number or Rural	Route Numbe				
			JACQUELINE STERN				CIRCLE, #7			21208		
			20a. Method of Disposition 1 ☑ Burial , 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Cont	Removal from State	Place of Disponentery, creed INGTON	osition (Name of matory or other pla G•	07/02/	2008	20c. Location - City o	tE, MD		
Balt			21. Signatura of Fundral Service Vice	Turser			STERSTOWN F	ROAD -		., INC. , MD 21208		
,	aw requires that some as been signe	ilner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	ter the mode of dyi	ing, such as cardiac or	respiratory arr	rest,	Approximate Interval Between Onset and Death		
			disease or condition a. Non Small Call Carcinoma of the Long									
			Due to (or as a consequence of):									
			Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
		Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	Due to (or as a consequence of):							
68760,		Medical	· ·	J								
		Med	IF FEMALE:	23c. If yes, outcome of pregna								
rds, P.O. Box		Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of de Month	elivery Day Year				
			Part II. Other significant conditions	, ,			i tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 □ Unknown					
Reco								24a. Was a autop: perfor	sy prior to med2 death?	autopsy findings available completion of cause of		
/ital		Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)							S/215/245		
of \		edical Certification: To I	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 170 SYCCE							ecify) Itospice		
Division of Vital Records,	nding ith. : After s funer		1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year)	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? M 1 □ Yes 2 □ No			200. Describe now injury occurred				
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
			29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To th withir To th comp	Me	29b. Signature and title of certifier						29d. Date signed (Month, Day, Year)			
			Dellah Keene			H4593/			June 30th 2008			
	/	1			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LETSTER STOWN MD							
	18		30. Name and address of person who	completed cause of death (Iter 25 MANN 3 32. Registrar's Signa	STREET	RETSTER	STOWN MI	0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 2008 aul lune 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Quaker Church Road
y Number 6. Sex 7. Age (In yrs. last birth If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Days 1**X** M 2□ F Kentucki 406-12-7750 Usual Residence of Decedent Feb 12, 192 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No treet 10g. Citizen of Whet Country? 10e. Street and Number hurch Koa Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑No Specify. Specify: 3 WiWidowed 4 □ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) F E lechnician 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>-09an</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) xawanter Unnet Wojciechowski
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3016 White Hall MD 2116 20c. Location - City or Town, State Date 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/2/2008 Baltimore, MD Daklawn Cemetery 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Belair
3 Newport Drive Forest Hill MD 21050 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE Due to (or as a consequence of): Sequentially list conditions, if a y leaf of control of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 21 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 2 100 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) ASSISTED LIVING Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical **Examiner** the death certificate be executed

Physician

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Mexical Experimenment be notified at

12 should be filed within 72 ho h and Mental Hygiene. 7 is marked other than "natu

Health and

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

Pages 1 and 2 should

or other traumatic

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

The law requires that

or Attending Physician:

/Medical

Director

by Funeral

Be ပ

Examiner burial-transit and cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical this certificate filled in by the funeral director, Be To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After

Completed Certification: To

Medical

State

23b. Was decedent pregnant

27. Manner of Death 2 Accident

5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 □Yes 2 □ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 ☐ Hornicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of geriffer,

29c. License number DØ\$16389 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VALARAO MO 1716 HARFORD RASU 105 FALLSTON MO 21047 PERPECTO

31. Date filed (Month, Day, Year)

2008 03

M. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ам 8:15 6/27/2008 Hazel Ruth Travers /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 □ M 2 🕅 F 213-50-0898 94 5/8/1914 Laurel, MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1KIYes 2 No Director MD Prince George's College Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20740 U.S.A. 7000 Dartmouth Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 N Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Spencer Thornton Windham Mary Lee Bond ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 73 N. Ridge Road, Greenbelt, Lynda L. Varda, Daughter MD 20770 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. 7/1/2008 Brentwood, MD Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 2078 Gasch's Funeral Home, P.A. onslan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Cerebrovascular Accident disease or condition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the attending pl If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown signed by 1 I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 TYes 2 \(\text{No.} 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: the Hospital or Attending Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide I ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu D0064615 June 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Dr., Rockville, MD 20850 Génevieve Wroblewski Registrar's Signature Year) 31. Date filed (Month, Day, State 3 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** R. Triplett 9:15 A M Milton June 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3107 Liberty Parkway Dundalk
If Under 1 Year | If Under 24 Hrs. Baltimore Co. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 3℃M 2 1 E Director 215-40-9395 65 Sept. 21,1942 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If Item Profiles Examinated. 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Directo Baltimore Maryland Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3107 Liberty Parkway 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Years Installation Carpet Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) Ukn. 17. Father's Name (First, Middle, Last) Ukn. Be ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1622 Parkman Ave. Linda Ochoa (Daughter) 21230 Baltimore, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 7/3/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of June ral Service Licen 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** oronary /Medical Due to (or as a consequence): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 2 No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 21 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5

☐ Residence 6 ☐ Other (Specify) this Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a tx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) within 2 and manner stated 29c. License number 29b. Signature and title of certifier D6411 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 MD Eastern Hangok 327 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **EVA Physician** SCOTT THOMPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battim tranklin Sal If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 4-5-1926 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ X Months Days Hours Min. 82 236-36-5961 VÍRGINIA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits items 23a or 28a-f show 1 ☐ Yes 2 No Director MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8101 SAGRAMORE ROAD 21237 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. 1 Never Married Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ XNo Specify: Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JULIUS SCOTT SARAH (YORK) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is THOMAS J. THOMPSON/HUSBAND 8101 SAGAMORE ROAD ROSEDALE, MD permit. Pages 1 an Department of Heal important: if item 27 any injury or other 1**-once. 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY 7-5-08 TIMONIUM, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscierotic Corentry **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1) FRENDENT NSULIN 1 ☐ Yes No 3 Probably 4 Unknown has been s le 2 should Completed PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate ha irector, page 2 2. N 1 ☐Yes 2 ☐No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 2 Accident 1 ☐ Yes 2 No ierai Director: / filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 691 PFE FFER AYL MO WGE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 12:50 AM Atherine 2008 01 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death HARF AIR If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country)
1916 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number Months Hours 1 □ M 2 🔀 F Days 92 213-34-0803 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 □Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 902 Southern Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Elizabeth Price Oscar Wolf Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 902 Southern Drive, Bel Air, Maryland 21014 Kay F. Reed / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mark's Epis. Cem. 7-3-08 Perryville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sign tug of Fune al Service kipensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 Will Cam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROVASCULAR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. REWAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an PERIPHERAL VASCULAR DISEASE

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

siclan and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed physician sthe burial attending pl been signed by the should be detached hls certificate has bil director, page 2 sh After t after death Director: , d In by the f within 24 hours after

To the Funeral Directory

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Physician

Examiner

Funeral

Director

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Department of Health
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Medical Certification: To

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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25. Was case referr	ed to medical		26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 🔯	No	Hospital: 1 ☐ Inpatient 2	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Other: 4 Other The specify)										
27. Manner of Death 1 Matural 2 ☐ Accident	5 Pending investigation			28c.	Injury at Work? 1 □ Yes	2 🗌 No	28d. Describe how injury of	occurred					
3 ☐ Suicide 4 ☐ Homîcide	6 Could not be determined		home, farm, street, f cify)	factory, of	fice		28f. Location (Street and I City or Town, State)	Number or Rural Route Number,					
29a. Certifier	1 Certifying Ph	nysician: To the best of my k	nowledge, death occ	curred at t	the time, c	date and place	e, and due to the cause(s) a	nd manner as stated.					

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D 45344

07/02/2008

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

MB 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)

6225- UNION AVE, HAVREDEGRACE MD21078 SURESH 32. Registrar's

State Registrar

Baltimore, Maryland 21215-0036

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Physician

/Medical

Examiner

Funeral

Director

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Physician /Medical Examiner

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To the Funeral Director: After thi
completely filled in by the funeral To the Hospital or Attend 25+1 EDDIE NAKHUDA, 31. Date filed (Month, Day, Year) State 0 3 2008 Registrar DHMH 17 Rev 1/2001

21. Signature Funeral Service Licens	Duda-Ruck Funeral 7922 Wise Ave. Du	indalk, Maryland 2	
23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Caust Final disease or condition resulting in death)	lications that caused the death. Do not enter the mode of dying, such as cardiac ne cause on each line. a	y respiratory arrest,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Exter or deriving Cause (Disease or injury that initiated events	Due to (or as a consequence of):		
resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of de Month	llivery Day Year
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II Other Ignificant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the second secon	Probably 4 Decknown
		1 Yes 2 10 1 Ye	s 2 No
25. Was case referred to medical examiner?		h (Check only one)	horaces
1 Yes 2 No 27. Non of Death tural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 7es 2 No	ome 5 Residence 6 Sther (Sp. 28d. Describe how injury occurred	ecify)
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,
29a. Certifier (Check only one) 2 Macket Exam	sician: To the best of my knowledge, death occurred at the time, date and place, iner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause(s) and manner a rred at the time, date and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
29b. Signature and the a certifier	0 1550 D1550	4 3	08

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month S Pay **Physician** ZOUP ,2008 Jane Frances Velton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anni ISVIY 17 i 651 in Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Mary land 1 □ M 2X F 214-22-9400 81 Dec. 16, Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 52 Forestdale Avenue 21061 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph A. Simmons Anna Steudel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 235 Bulle Rock Drd, Centreville, MD 21617

Date 20c. Location - City or Youn, State Victor G. Velton, Jr. Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐ Ponation 5 ☐ Other (Specify) Foudon Park Cemetery 7-5-2008 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. Simple of Funeral Service Li 2/1328 Sulphur Spring Rd., Arbutus, MD 21227 Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. In the cause of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Hospital or Attending Physician: The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached in 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1-Watural 5 ☐ Pending investigation n 24 hours after death.

Ie Funeral Director: Aft bletely filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi Medical (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

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Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Funeral

Director

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ortant: If Item 27 Is marked other than "natural", or Items 23a or? Injury or other traumatic event, the Medical Examiner must be n

permit. Page Department o Important: If any Injury or

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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and attending physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

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ysiciall	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fet. 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic p			23d. Date of delivery Month Day Year
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acioni.	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
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מוניםו		nysician: To the best of my knowniner: On the basis of examinand manner stated.				e(s) and manner as stated. and place, and due to the cause(s)

29c. License number

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29d. Date signed (Month, Day, Year)

June 25, 2008

21224

State Registrar

within 24 hours a

Groves EASTERN 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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DHMH 17 Rev 1/2001

29b. Signature and title of certifie

AVENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:56PM JUN 2008 Elvira Maria /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick ollege If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Hours 1 □ M 2 F 578-80-125 Equador Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Ves 2 No Directo rederick 10g. Citizen of What Country? 10e. Street and Number 21702 SA ay Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Hispanic 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tospita 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Serrano ဥ Francisco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick, MD 2/1 MD 21702 Lorentty Patricia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🌃 Cremation 3 Removal from State Smithsburb, MD 110 West South Street July 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Gary L. Rollins Funeral Home Frederick MD 21705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mct astatic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Completed by Be Certification: To

Physician /Medical **Examiner** Hospital or Attending Physician; The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, the attending physician

Funeral

Director

or items 23a or 28a-f show aminer must be notified at

nit. Pages 1 and 2 should be filed within 72 hours after nartment of Health and Mental Hygiene.

ortant: If Item 27 is marked other than "natural", or ite Injury or other traumatic event, the Medical Examines

permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0036

death with the Maryland

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within 24 hours a To the Funeral L

Part II. Other significant conditions	contributing to death but not resulting in the unde	enying cause given in Part I.	23e. Did tobacco use contribute to the cause of deaths
			1 Yes 2 10 3 Probably 4 Unknown
			24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical		26. Place of De	eath Check onl one
examiner? 1 Yes No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		t, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check onlone)	1 Certifying Physic 2 Medical Examine
29b. Signatur	and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number MD D60417 2008

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30.	Nam	е апо	address	of pe	rson v	vao co	mpleted	cause	of dear	th (Item	23a)	(Type,	Print'

Tohnson DV. Frederick 21702 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 3 2008

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Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21582 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July **Physician** 2008 4:30P M MARY JO WARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7227 Lanark Road Baltimore 8. Date of Birth (Month, Day, Year) NoV 11, 1922 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Maryland 1 M XX F 85 216-16-9252 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 7227 Lanark Road Funeral 12. Was Decedent Ever in U.S. Armed Foces? 1 ☐ Yes At No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes aXXVo ģ XX Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Francis Hoffman Sally Augusta Taylor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Albert Klinefelter Ward Jr Son |7227 Lanark Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ★ Fremation 3 ☐ Removal from State Date Green Mount Crematory July 7, 2008 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of FacilityMitchell-Wiedefeld Funeral Home Inc nature of Funeral Service Licensy 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

Department of Health a Important: If Item 27 Is any Injury or other trainonce.

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician:

		Due to (or as a consequence or):		
ıminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):		
dical Exa	resulting in death) Last	Due to (or as a consequence of):		
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	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying	g calse given in Part I. 23e. Did	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Completed by	CARG End	apritic Valve T	1 Yes	topsy prior to completion of cause of death?
Be (25. Was case referred to medical		26. Place of Death (Check only	y one)
To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5 Re	sidence 6 Other (Specify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 28d. Describ	e how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fact building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)
Medical (ysician: To the best of my knowledge, death occurr niner: On the basis of examination and/or investigat and manner, stated.		
N N	29b. Signature and title of certifier	2 // 21 /	29c. License number	29d. Dete signed (Month, Day, Year)

State

Registrar

7505 OSler Dr. 214. Towson, MD 21200

mesh ouglas Cashens M22068

Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Doug 31. Date filed (Month, Day, Year)

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			For State Registrar	State of Maryland	d / Department of Health and N Certificate of Death	lental Hygie	ne 2008	21583
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أر	Examir	ner	4a. Facility Name (If not institution, give	Road	4b. City, Town, or Location of Death	- 4	4c. County of Death	and
	Funeral		5. Social Security Number 6. Se		ast birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	18	Yrs. World Days Trous Will.			USHOOK, PA
	arylan show	_	10a. State 10b. County	10c. City,	, Town or Location		10	0d. Inside City Limits
	the M.	Director	10e. Street and Number	ord	White Ford	100	Citizen of What Coun	1 ☐ Yes 2√2 No
	th with		1827 Ridge	Road	21160	1.03.	USA	,.
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marinal Examinar must be rediffied at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
036	ours aff	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 MYes 2	1 □Yes 2 ☑ No Specify:		Specify:	rite
15-0	"natur	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ina .	. Kind of Business/Ind	lustry
212	d withir jiene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Self Employe		dwal M	
pu	be filed winter Hygier ed other the event, the	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid		1101013
Maryland 21215-0036	should be and Mental is marked o	은	19a. Informant's Name/Relationship (7)	Dilliams	19b. Mailing Address (Street and Number or Rur	nadea		ington
<u>≅</u>	1 and 2 s Health ar em 27 is other trau		Mildred William	ns - socuse.	1827 Ridge Rood U	White Fo	cd mb	21160
ore	Pages 1 and the state of the st		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	20b. Pla	ace of Disposition (Name of metery, crematory or other place) no Funeral Chapel		. Location - City or To	
Baltimore,	Pa ant: ury		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	Crem	nation Services-Idelaid	2008 Fo	rest Hill,	mD.
g	permit. Departi Importa any inji		Tagranda of the later is	marta	Evans Funeral Chay 3 Newport Drive	pel + Crema	ition Service	s-19elair nd 21050
			23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the death. ne cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	The state of the s	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Liver 40	aitue			Onset and Death
	Examiner			Due to (or as a constique	Metal Cols			64
V	ted sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):			CM
	execu in and ial-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):			911
08/PN	ificate be executed g physician and as the burial-transit	edical		d				
			IF FEMALE:	23c. If yes, outcome of pregnan	cv		00 1 D 4 1 1 1 1 1	
7. BOX	death cer e attendin ed for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3 Ectopic pregnancy		23d. Date of delive Month	ry Day Year
7.	hat the ed by th	Phys	9 Unknown	9 Unknown	ting in the underlying cause given in Part I.	220 Did tohoon	co use contribute to the	a gauge of death?
ras,	quires t n signe ald be c	d by	Taren. Other significant conditions co	misuming to death but not result	ang in the underlying cause given in Part i.	1 ☐ Yes	\ /	ably 4 Unknown
ecords	law rec as bee 2 shou	Completed				24a. Was an	24b. Were autop	osy findings available
ב ה	r: The icate h ; page	S				autopsy performed 1 ☐ Yes 2	? death?	npletion of cause of 2 □ No
VII	yslciar s certif director	o Be	25. Was case referred to medical examiner?	lospital:	26. Place of Death R/Outpatient 3 □ DOA Other: 4 □ Nursing Ho	5 4	0.000	
vision of	ng Phy fiter thi meral (F 4	27. Manner of Death 1 Natural 5 □ Pending			28d. Describe how in	6 ☐ Other (Specify njury occurred)
<u>S</u>	uttendi death. ctor: A / the fu	icati	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No	001		
2	al or A s after il Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	ne, farm, street, factory, office	City or Town, St	and Number or Rural ate)	Houte Number,
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	edical ((Uneck only 2 Medical Exami	ner: On the basis of examination	ledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
	o the vithin 2 or the complet	Med	one) 29b. Signature and title of certifier	and manner stated.	29c License number		Date signed (Month, E	
	. > - 0		X Just Hausel	1/ Baltimore	my one 7 1,0160			2008
	1.41		30. Name and address of person who co	mpleted cause of death (item 2	Par 1995/00 Print Theet Balt	was kit	21201	0,000
*.	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re Angeli s		/	
	Registra		JUL 0 3 2008	Allegan is.	Marie			

DHMH 17 Rev 1/2001

EDWAL WILLIAMS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM#1, per PLYS. C881 7/3 (8 WS)
State of Maryland / Department of Health and Mental Hygiene
2008 Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Wat Son Helena June 0556 AM Watson 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/ABaltimore Bon Secours Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1 □ M 2 🗹 F 212-46-4469 30. 1946 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 1 Yes 2 □ No Baltimore N/AMaryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 1833 W. Lanvale Street USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3 □Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Administration <u>12th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Hamlett John Childs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1815 W. Mulberry Street Baltimore, Md 21223 Peiron Butler/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 730708 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Baltimore National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licens 10 Part Enter the disea block, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Suspected my ocarded
Due to or as a consequence of): Atheroscherotic Cardiovascular diserse Due to (or as a consequence of): Chronic obstructure Pulmonary Disense Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or

"natural", or items

permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu. any injury or other traumatic event, the Medical once.

Director

Funeral

Completed by

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

/Medical

The law requires that the death certificate be executed burial-transit physician the as for use ed by the a detached f signed I

page 2 should certificate has funeral director, this After t

Division or Vital Records, P.O. Box 68760,

completely within 24

Hospital or Attending Physician:

filled in by

death 24 hours after death e Funeral Director:

mediate Cause (Final disease or condition resulting in death) sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖼 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pulmonary 1 Yes 2 No 3 Probably 4 Monknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of continer D0060192 June 25 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bonsecours Hospital 2000 West Bultimore ST Bultimore MD 21223 Scott L. Diering MD

31. Date filed (Month, Edy, Year)

JUL 0 3 2008 32. Registrar's Signature

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 27,28a-f per me. 281,07,02/08dhb Reg. No. 2008 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Williams Month Year 19:34 M Physician /Medical Michael June 16 8002 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** Maryland 1 M 2 □ F 4-86-6133 Director Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 Ces 2 No Director "natural", or Items 23a or 28a-f s edical Examiner must be notified 1+imore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA Willinger Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 25 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 🔑 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Decedents obsult Occupation (Give kind of work done during most of working life. DO NOT use retired))FficeAssist Elementary/Secondary (0-12) College (1-4 or 5+) other than lame (First, Middle, Last) 17. Father's Baltimore, Maryland Be Is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. Important; If Item 27 Is any injury or other tra once. 20b. Place of Disposition (Name o cemetery, crematory or other 20a. Method o Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of 21. Signature of Funeral Service Licensee M01363 Approximate Interval Between Onset and Death 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. hemmorrhage Immediate Cause (Final exanguinating hour **Physician** disease or condition resulting in death) Due to (or as consequent of) /Medical Examiner APPROVED BY MEDICAL EXAMINATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury A. Mubil M.D. Examine Due to (or as a nonsequence of) burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 TEctopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Records, 3 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 🗌 No 1 Yes Division of Vital To the Funeral Director: After this certifica completely filled in by the funeral director, 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? 1 ☑ Yes 2 ☐ No Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 🗆 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred

Loss of blood through 28c. Injury at Work? 28b. Time of 27. Manger of Death Medical Certification: 5 Pending investigation I or Attending F after death. Month, Day Year) 16/2008 6:20 Natural 1 Yes 2 No \mathbf{p}_{M} 2 X Accident dialysis port 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 1125 Willinger 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Court, Baltimore, MD 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2008 1)0047291 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Fred

31. Date filed (Month, Day, Year)

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02

2008

36. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05010 State of Maryland / Department of Health and Mental Hygiene Carla Williams Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 29, 2008 1009 hrs Medical Examiner c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Baltimore 208 Diener Place Apt. # 202 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. Country) Director 215-86-0511 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No 28a-f show Marylan or items Z3a or 28a-f she must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21229 Diener 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 No Yes 2 No Yes 4 Divorced If Yes Give Year imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after 3 Widowed is marked other than "natural", atic event, the Medical Examiner ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) WK. unemplo of Health and Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Las awrence 19b. Mailing Address (Street and Number or Rural Rou e Number, City or Town, State, Zip Code) 2132 g 19a. Informant's Name/Relationship (Type, Print) t. 202 Tace Baltimore If item 27 20c. Location - City of Town, Sta 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marylan 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical aAlcohol & methadone intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed 23a, PlI,2/,28a-t, perME, g881 7/18/08 Physician/Medical AMENDED physician a **X** UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death led by the attending detached for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.0. Yes 2 No 3 Probably 4 ✔ Unknown ģ Cocaine use After this certificate has been sign funeral director, page 2 should be 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital æ Nursing Home 5 Residence 6 Other: Scene Hospital: Other 1 DOA ER/Outpatient Inpatient 2 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 X No Natural Pending Fnd 6/29/08 Fnd 1000 hts hours after death. the Funeral Director: Investigation 28f. Location (Street and Number of Rural Rayte Number City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 202 Baltimore, MD Suicide determined (Specify) residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 **Nedical** one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 30, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Iten, 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		aryland / De	-	te of De		Re 2. Date of Death	g. No. 2	800	2 58
Physici /Medic		1. Decedent's Name (First, Middle, L Pama	g Will	liams				Month June	30 Z	Year 2008	3.084M
Examin			alth & Rehab C	enter e (In yrs. last birthda			ation of Death icott City Juder 24 Hrs.	8. Date of Birth	4c. Cour		ward blace (State or Foreigi
Funeral Director		5. Social Security Number 6. 216.40.7372 Usual Residence of Decedent	1 M 2 1 F	66 Yrs	Months		ours Min.	(Month, Day, Nov 25		Cour	unknow
Maryland f show led at	tor	10a. State 10b. County	oward	10c. City, Town or	Location	EI	licott City			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	Director	10e. Street and Number 3004 North Ridge Roa	d		10f. Z	ip Code	21043	10	g. Citizen	of What Cour	
172 hours after death with the Maryland "natural"; or items 23a or 28a-f show idical Examiner must be notified at	by Funeral	11. Marital Status 1 Marital Status 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1	Ever in U.S. 1	3. Was Dec			ecify Yes or No- Rican, etc.)	E	Race - Americ Black, White,	can Indian, etc.
filed within 72 hou Hygiene. ther than "natura int, the Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed)	cation 16a. Deceding the completed 16a. Deceding (Give life. I			edent's Usual Occupation e kind of work done during most of working DO NOT use retired) disabled			16b. Kind of Business/Industry	
be filed tal Hyg d othe event,	B B	17. Father's Name (First, Middle, La						e (First, Middle, N		name)	-
2 should and Men is marke aumatic	2	19a. Informant's Name/Relationship	(Type. Print)		ailing Addres	ss (Street and	Number or Rur	ral Route Number	City or To		Code)
of Health of Health I Item 27		Ofelia Ross 20a. Method of Disposition 1 Burial 2 Cremation 3	□Removal from State	20b. Place of Di	sposition (N			e Columbia	·	046 on - City or T	own, State
permit. Pages Department of Important: If Its any Injury or o		4 □ Donation 5 □ Other (Spe 21. Signal up of Ful eral Service Li.	cify)		and Address of	-	03, 2008		Baltimo	re, MD	
iticate be executed Examiner bhysician and bhysician and stree burial-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as Due to (or as	a consequence of):	eves	Deabe ntea	eles M	lelli tu	9		
The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3⊟Ectopic 5⊟ Other (23d. Date of delive Month			very Day Year
w requires that to be a signed by should be detact	by	Part II. Other significant condition	s contributing to death b	out not resulting in th	ne underlying	cause given i	n Part I.	23e. Did to			the cause of death?
The law req cate has beer page 2 shou	Completed								med? 2 No	prior to c death?	opsy findings availa ompletion of cause 2 ☐ No
Physician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	ent 2 ☐ ER/Outpa	atient 3∐ l	DOA Other:	4 Nursing H	th <i>Check onl or</i> ome 5□Resid		Other (Spec	rify)
ding i		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investiga 3 □ Suicide 6 □ Could no	t ha	ay Year) Inju	ury M		s 2 □ No	28d. Describe h			
To the Hospital r Attend within 24 hours a er dea'h To the Funeral Director completely filled in by the	Certification:	4 Homicide determin	building, e	jury - At home, farm tc. (Specify)			data and t	City or Tow	n, State)		ral Route Number,
To the Hospital or within 24 hours are To the Funeral Discompletely filled in	Medical		Physician: To the best caminer: On the basis of and manner st	of examination and/				irred at the time, (date and pla	ace, and due	to the cause(s)
To the within the total complex comple	M	29b. Signature and title of certifier				29c. License no	3064	-1	Jun	igned (<i>Montl</i> l 30	200 §
3		30. Name and address of person w	no completed cause of		ype, Print)	Back	River	Nede	Ros	O Ess	2008 ex Md 4
St	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1 de 12						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6/29/2008 5:30 a. M Physician Genevieve Jones Williams /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hyattsville Sacred Heart Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days 1□M 2**⊠**F Maryland 92 4/22/1916 579-05-6273 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 28a-f show at 1 X Yes 2 ☐ No a or 28a-f sho Director Hyattsville Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20782 r than "natural", or items 23a the Medical Examiner must b 5805 Queens Chapel Road filed within 72 hours after death Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Mary Elizabeth Anderson Sylvester Charles Bond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5608 Ruatan St., Berwyn Heights, MD 20740 Daniel F. Zell, Sr., Son-in-law 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 x Burial 2 □ Cremation 3 □ Removal from State 7/2/2008 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 4739 Baltimore Avenue 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Lund 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Zheimens Cnknown Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 3 ☐ Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 2AI No Doon intake + ailure 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 | Pending 1 Yes 2 No death. investigation after death Director: in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours aft To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43121 (howdy, m) erson who completed cause of death (Item 23a) (Type, Print)

CHOWDHURY, MD, 15216 DINO DRIVE I BURTONS VILLE, MD
20866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NURUL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2008 Registrar

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of I	lealth a		Reg. No.	
	Physici		1. Decedent's Name (First, Midd Benjamin D. W					2. Date of Dea Month June 26	Day Year	3. Time of Death 1:40 AM
	/Medic Examir		4a. Facility Name (If not institution Dove House	on, give street and number)		4b. City, Town, o		of Death	4c. County of Dea	th
ļ	Funeral Director		5. Social Security Number 218–14–6006	6. Sex 7. Ag	ge (In yrs. last birthday 83 Yrs.	Months Days		24 Hrs. 8. Date of Birt Min. (Month, Da Nov 30	y, Year) C	thplace (State or Foreign ountry) t Virginia
	Maryland e-f show	ctor	Usual Residence of Decedent 10a. State 10b. Count MD Balt	imore	10c. City, Town or L					10d. Inside City Limits
	3a or 28	al Dire	10e. Street and Number 4217 Chapel Ro	ad #204		10f. Zip Code 212	236		10g. Citizen of What C USA	ountry?
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or items 23a or 28e-f show event, I're Medical Examinar must be nutified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		gin? (Specify Yes or No , Puerto Rican, etc.)			
9500-6121	vithin 72 hou ne. hen "netura e Madical E	Completed	15. Decede (Specify only highs Elementary/Secondary (0-12) 1 2	edent's Usual Occup e kind of work done DO NOT use retire	during mos	t of working	16b. Kind of Business	ŕ		
וא פר		Be Co	17. Father's Name (First, Middle		suj	ervisor		er's Name (First, Middle,		company
Maryland	2 should be and Mental is marked eumatic ev	To	Benjamin Whit		19b Mail	ing Address (Street		er or Rural Route Number		Zip Code)
	es 1 and 2 should b of Health and Ment f item 27 is marked r other treumatic e		Josephne Whitr		4217	Chapel		204 Baltimo	ore, MD 21	236
Baltimore,	permit. Pages 1 Department of He Importent: If iten any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation '4 ☒ Donation 5 ☐ Other (Specify)		ematory or other pla	[Date	20c. Location - City o	
g	Departimpor any in once.		21. Signature of Funeral Service	sticence Day	ector S	2. Name and Addre tate Anat altimore,	ess of Facili Comy B MD	oard 655 W. 21201	Baltimore	Street
	ate be executed Thysician and investment in the burdal-transit	Ilcal Examiner	234 Part1 Enter the disease, of shock or heart failure. Lis immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):			cardiac or respiratory at	rrest,	Approximate Interval Between Onset and Death
C. BOX 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	ey .		23d. Date of delivery Month Day Ye	
rds, P.	w requires that the de been signed by the should be detached	b	Part II. Other significant condit	ions contributing to death t	out not resulting in the	underlying cause gi	ven in Part I	. 23e. Did t	obacco use contribute Yes 2 ☑No 3 ☐ F	to the cause of death? Probably 4 □Unknown
Hecord	The ate h	Completed						24a. Was autop perfo 1 🗆 Yes	an 24b. Were a prior to death? 227No 1 79	utopsy findings available completion of cause of
Division of Vital	ng Phy Iter this meral d	Certification; To Be	3 ☐ Suicide 6 ☐ Could	Hospital: 1 ☐ Inpati 28a. Date of Inj (Month, Datigation I not be mined 28e. Place of In		of 28c. Inju	her: 4 Ni iry at ork?] Yes 2 D	No	dence Other (Sp how injury occurred Street and Number or I	
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	To the within 2 To the complet	Medical	29b. Signature and title of certifit	er and manner st	M)	29c. Licen	se number	8	29d. Date signed (<i>Mor</i>	nth, Day, Year)
			30. Name and address of person	the MD	death (Item 23a) (Type	-n Ceute	St	WESHIN	SHE IMDO	1157
	Sta Registi		31. Date filed (Month, Day, Year		rar's Signature				•	

			1 - State Registrar	State of Ma	aryland	d / Depa <i>Cer</i>	rtment o	f Healt of Dea	th and M a <i>th</i>		giene Reg. No		21590
			Decedent's Name (First, Middle, Last)							2. Date of De	ath		3. Time of Death
	Physic		ANNA (NMN) WESSE	TS						JUNE 3	Da O	y Year 2008	19:05 M
	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, Tow	n, or Local	tion of Death			. County of Death	
			Harford Memorial	Hospital	L		Havre	e de	Grace			Harford	
	Funeral		5. Social Security Number 6. Sex	7. Ag		ast birthday)	If Under 1 Ye Months Da			8. Date of Bir (Month, Da	th v. Year	9. Birthp	place (State or Foreign
	Director		216-48-2770	M 25%F	90	Yrs.	Wioriano Bu	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	dio iviiii:	Mar. 2		1918 Mary	
_	pur *		Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or Lo	cation					1	I Od. Inside City Limits
	laryli	ō	Maryland Harford		Jop								1 ☐ Yes 2 🛣 No
	the A	Director	10e. Street and Number		o o pri		10f. Zip Cod	10			10g Ci	tizen of What Cour	ntry?
	death with the Maryland oms 23s or 28s-f ehow if must be notified at						2108						
	leath ns 23	Funeral	1028 Emmerick D	12. Was Decedent	Ever in U.S	S. 13. V			c Origin? (Spe	ecify Yes or No	USZ	14. Race - Americ	can Indian,
	₽ ₹ ₽	핕	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		l I	Yes, specify (Cuban, Me	xican, Puerto	Rican, etc.)		Black, White,	etc.
3	burs after death with the Marylan rei', or items 23s or 28s-f ehow Examinat must be notified at	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐Yes 21X	No Spe	ecify:			Specify: W	hite
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0 5	Lip of the	npie	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	OO NOT use re	tired)		9			
	filed w Hygier other th	ပိ	6			Homem	aker					Own Home	
2	be filed within 72 ho ital Hygiene. Id other then "natu	Be	17. Father's Name (First, Middle, Last) Casper (nmn) Hors	· +						e (First, Middle ta (nmn			
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08 Maryland	d 2 si th an 7 is r	1 5	19a. Informant's Name/Relationship (Ty		_						and the	or Town, State, Zip	
10	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than ery injury or other traumatic event, Ina Means in page.	8	Linda A. Brown /	_baugnter	20b. Pl	ace of Dispo	sition (Name o	f		Date Ma		and 21085 ocation - City or To	
(e 36/	Pages nent of l int: if it		12☐ Burial /2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		•	natory or other		D=1- 7	F 00	D	1+	Maserland
10	artme	1	21. Signature of Funeral Service Line	* ala	HOT.							ltimore,	Maryland
a a	permit. Departr Import		1/ 1/< /	1000	1					me, P.A			
			23a. Part 1. Enter the disease, or complishook, or heart failure. List only or	cations that caused	the death	. Do not ent	31/ COK or the mode of	dying, suc	ry Road	or respiratory a	igaoi irrest,	n, Maryla	Approximate
	Physician		Immediate Cause (Final	ne cause on each III	ne.	tole	1_ #	776	ul				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Doe to (or as	a consequ	lence of):	, , ,		ma	-			
0	Examiner			pne	ein	non	10						
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S	eath certifi attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 ☐ Fetal	death 3□	Ectopic pregna					23d. Date of delive Month	ery Day Year
	t the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or de	atn 5∟	Other (specify	"					
5e	res that thigh each of the desired by	F.	Part II. Other significant conditions con	ntributing to death b	ut not resu	Iting in the ur	nderlying cause	given in f	Part I.	23e. Did 1	tobacco	use contribute to t	he cause of death?
& Sp	The law requires that the death certific the law requires that the death certific to the last been signed by the attending page 2 should be detached for use as	d by								1 🗆	Yes 2	Prot	bably 4 Unknown
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Ahna of Vital	nysiciu nis cerl direct	To B	examiner?	lospital:	ent 2 🗆 E	ER/Outpatien	t 3 DOA	Othor			1000	6 □Other (Specia	fv)
A	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Inju (Month, Da	ry v Year)	28b. Time of Injury		njury at Work?		28d. Describe	how inju	ury occurred	
.0	Attending Physician: r death. sctor: After this certifica	atic	1 ■ Natural 5 Pending 2 Accident investigation	(,	,,		1 🗆 Yes	2 □ No				
\dot{A} NN $\dot{\alpha}$ \dot{W} ϕ 55.	I or Attendater deatl	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injuding, et	ury - At hor c. (Specify	me, farm, str	eet, factory, off	ice		28f. Location (City or To	Street a	nd Number or Rura te)	al Route Number,
	ital or rai Dir lled in			1									
	To the Hospital within 24 hours a To the Funerail completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Check only one)	ner: On the basis of	f examinati	vledge, death ion and/or inv	occurred at the restigation, in r	e time, da ny opinion	te and place, , death occuri	and due to the red at the time,	cause(: date ar	s) and manner as s nd place, and due t	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifien	and manner sta	ated.		29c. Lic	ense num	ıber		29d. D	ate signed (Month,	Day Year
	5 7 K 9		m-047	Oll 21	M	1)	Do	56 1	102	_	0	6/20	108
	n		30. Name and address of person who co	moleted cause of d	leath (Itom	23a) /Time	Print)		<u></u>			7 0	, , ,
	3		Mohammad Afzal, 1					7\170 -	Haure	de Gra	200	Man-7	21078
1	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure	STITOIT .	ave./	IMATE	ue Gra	ace,	MaryLand	a =====
	Registr	ar	1111 0 3 2008	DONOS	100	The same of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items of Meryland Pepartment of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ELSIE WEDLAKE JUNE 3Ó, 2008 9:20 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MARINER HEALTH OVERLEA BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex Months Days 1 M 2 X F Hours MD. 101 218-12-2108 MAR 25,1907 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4716 BLUE RIDGE AVE 21206 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify. WHITE Specify: 3 Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN UNKNOWN NEIBUHR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY BUX-POA 4716 BLUE RIDGE AVE BALTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State METRO CREMATORY 7/3/08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 enter the dise complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? death? 1 Yes 2√ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Inpatient Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

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Funeral

Director

show r 28a-f sh notified

ms 23a or 7

Examiner

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"natural"

item 27 Is marked other than "nature other traumatic event, the Medical

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examine physician and s the burial-trans Physician/Medical as signed by the attending be detached for use as Be Completed by certificate has been signi rector, page 2 should be Certification: To After this 24 hours after death. the filled in by

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

Hospital

To the l within 24

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner? 250 No 1 Tes 27. Manner of Death

5 Pending investigation 6 Could not be determined

2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural 2 ☐ Accident

3 ☐ Suicide

4 Homicide

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Raven Blud, Bultimore NO 2123

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

Medical

31. Date filed (Month, Day, Year)

03 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



5601-Loch

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 Year Month **Physician** 2240 6 Leonard Jackson Alvey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day), Dec. 24, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 212-38-7053 71 Yrs. 1936 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show notified at 1 ☐ Yes 2 ☑ No Director MD St. Mary's Leonardtown 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai", or items 23a or Examiner must be United States 23560 Greenbrier Road 20650 Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after XYes 2 □ No Yes, Give 'ear or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White δ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Mexical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Mechanic other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot Mary Eva Hazel James Leach Alvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 23560 Greenbrier Road, Leonardtown, Maryland 20650 Lois Ann Alvey (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 N Burial 2 □ Cremation 3 □ Removal from State Leonardtown, Maryland Charles Memorial Cem. 6/26/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licenses Shawn Aylesworth #101521 22955 Hollywood Rd., Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causir on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of P.O. Box 68760, physician Physician/Medical attending properties of the properties of the second secon IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 Yes 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1□ Yes 2 - No or Attending Physician: 25. Was case referred medical examiner? ector. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 20 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To funeral dir 27. Mannal of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0050 Thomas, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 5

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ye ar Physician 4:10 PM James 106 2008 bert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Peninsula Regional

16. Sex Examiner Medical Salisbury NICOMICE Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. MD 218-20 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tr∝ Wedical Exantment round to notified at 1 Yes 2 No Snow Hil Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3181 lartin Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify ģ Black 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other traumatic event, If * Magance. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be rriet ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linkside Dr. Baltimore MD 21234 dward 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State P13413008 Snow Hill, MD Ebenezer UNC 4 Donation 5 Dother (Specify) 21 Signature of Liberta Servi & Licensee 22. Name and Address of Facility 917 W. ISabella St ON 10816 CIM L Bennie Smith Fureial Home Approximate Interval Between Onset and Death 24 hours 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Final **Physician** COVERNO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. the cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions cogtributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate arthritis 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No sephi 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 □ Yes Inpatient Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 🗌 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of rtifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Regional Medical Cent 31. Date filed (Mont State Registrar

	1	For State Registrar	S	tate of	Maryland		artmen rtificate			and M	ental Hy	/giene Reg. No.	200		1594
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Examine		4a. Facility Name (If not institut	on, give stre	et and nun	nber)				Location o	of Death			County of Dea		
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Funeral	-	5. Social Security Number	6. Sex	2□ F	7. Age <i>(In yrs. I</i> 86	a <i>sı birtinday)</i> Yrs.	Months	Days	Hours	Min.	Jan. 8	ay, Year)		ountry) Canada	
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н	Funeral		5. Social Security Number 220-28-6585	6. Se	ex □ M 2/CX F	7. Age (In yi	rs. <i>last birthday)</i> 71 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da OCt. 3	n V. Ye <i>ar)</i> 1	936	Coun	lace (State of	o <i>r I</i> -oreign
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	within 72 hours after death with the Maryland ane. then "naturel", or Items 23a or 28a-f show Ite Madical Examilier must be multing a	Funeral	11. Marital Status		Armed F		U.S. 13.	Was Deced If Yes, spec	dent of Hi city Cuba	ispanic Ori ın, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Black, 1			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 **Physician** 8:10 PM June CARROLL LEE BOYER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) SEPT. 5, 1 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** 215-26-8029 1**X** M 2 ☐ F Yrs. 83 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 1 ☐ Yes 2X No BOONSBORO WASHINGTON MARYLAND Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 21713 U.S.A. 5658 AMOS REEDER ROAD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married Married 1 ∐ Yes 2 LXNo Saltimore, Maryland 21215-0036 Specify Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than "I College (1-4or 5+) 5+ Elementary/Secondary (0-12) MINISTER LUTHERAN CHURCH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be CARROLL EUGENE BOYER BEULAH PEARL AHALT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health an Important: If item 27 is many injury or other 5658 AMOS REEDER ROAD, BOONSBORO, MARYLAND 21713 MARIE K. BOYER, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MIDDLETOWN LUTH. CEM. 6/28/2008 MIDDLETOWN, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Se Jic Licensee 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME, P.A. 7606 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 21713 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) (weins meho) Physician month Theorene /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter the configuration of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the ! IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours a er deat e Funeral Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 041667 milam MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Comput theserohan MO 54-41 Michael 11110 meele 31. Date filed (Month, Day, Year) State JUN 24 2008 Registrar

2. Date of Death

Columbia, MD 21044

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)

Physician
/Medical
Examiner

Funeral

Director

death with the Maryland r 28a-f show notified at "natural", or Items 23a or dical Examiner must be is 1 and 2 should be filed within 72 hours after of Heath and Mental Hygiene. item 27 is marked other than "naturar", or ite other traumatic event, the Medical Examine. Pages 1 permit. Page Department o Important: If any Injury or = 5

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

requires that the death certificate be executed the burial-tra physician use as for signed by 2 should certificate or Attending Physician: this funeral after death the filled in by

Division or Vital Records, P.O, Box 68760,

Month Year CLARICE MAXINE BROWN 11:30A M 6 2008 11 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death LAUREL REGINAL HOSPITAL Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 🗓 F 88 254-10-2980 6 1920 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TyYes 2 □ No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16114 Pond Meadow Lane 20716 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify. ģ 3₺Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucius Skinner McClain Willie Franklin Hartley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16114 Pond Meadow Lane, Bowie, Maryland 20716 Raymond Brown/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 6-17-2008 Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Altered Mental Stature Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Atrial Fibrilation - rapid ventricular response Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ 27. Manne of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🛩 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D64874 6/11/2008 aven Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Patuxent Parkway, Ste 200

DHMH 17 Rev 1/2001

State

Registrar

Bavani, MD

JUN 1 7 2008

31. Date filed (Month, Day, Year)

within 24 hours a

Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 2008 June 27, Robert Vaughn Beard 10:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood of Williamsport Williamsport Washington 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Director 215-20-7584 26, 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, Its Medical Examinations. Director 1 ☐ Yes 2 X No MD Williampsport Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainmant. 12 Refridgeration Technician Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie Higman ပ Vernon C. Beard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane B. Beard/ Wife 16505 Virginia Ave., Williamsport, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 6/29/2008 Smithsburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel 5. Mark 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one clause on each inc. Approximate Interval Between Onserand Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): cords, P.O. Box 68760, A. requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐Yes 2 No funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title completed cause State 03 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner norsing, linton INTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** CHASE CITY, VA. Months Days Hours 578-56-0852 1 X M 2 □ F 6 7-2-1943 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic everal." 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Washington Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 SA HIGHVIEN +lace Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance HOTEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VETA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Fural Foute Number, City or Town, State, Zip Code)
200 H16HV16W PLACE SOUTHEAST
WGSHINGTON, D.C. 20032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National 6/21/08 Suitland, MD. 4 ☐ Donation 5 ☐ Other (Specify) K. HENRY FUNERAL HOME WASH-DC. 20002 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Auto Physician KRSPICITY /Medical **Examiner** Zepti Cema Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 201 gaine Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2X No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760

State Registrar 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JUN 2 0 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 OID Branch Civenus #409

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

mary land

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Physicia		Registrar 1. Decedent's Name (First, Middle	,Last)					12	2. Date of Death Month	Dav Year	3. Time of D 2239 h	
Me LExamir	ner	Adrian Chaves 4a. Facility Name (if not institution				4b. City, Town	or Location	of Death	June 23, 20	4c. County of D		
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1	Year If Un Days Hou	der 24Hrs.	4	` E	. Birthplace (State oreign Guate	mala
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Maryls - 28a-f	Director	10e. Street and Number 232 Bohemia A	70niio			10f. Zip Co 219			10	g. Citizen of What Guatema		
1715-0036 de filed within 72 hours after death with the Maryland fental Hygiene. narked other than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at once.		11. Marital Status		cedent Ever in I	J.S. 13. W	as Decedent of	f Hispanic C	origin? (Spe	ecify Yes or No-		American Indian, E	ЗIack,
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21215-0036 und be filed within ? Mental Hygiene. marked other than e event, the Medica	Be Co	17. Father's Name (First, Middle, Pedro Chabes	Last) -							ras deoc	ute	
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Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra		4 Donation 5 Other State 21. Signature of Funeral Service	ecify:					ilev F	amily F	uneral Ho ark, DE	ome	
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Physician Medical		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as caused in separations failure. List only one cause on each line.										n Onset and Death
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		Sequentially list conditions, if any, leading to immediate Cause File Underway Cause Due to (or as a consequence of):										
Cause. Enter Underlying Cause C. (Disease or injury that initiated											_	
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Box 68760, e death certificate be the attending physic ed for use as the buri	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?		s, outcome of pre birth		Fetal death	3 Ed	opic pregna	ancy	Month	Day	Year
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O. B. It the de by the		Part II. Other significant condi			ot resulting in th	e underlying c	ause given i	n Part I.		obacco use contrib		
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rast after death. The intercor: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed by	<u> </u>							1 Ye		/ere autopsy findi	
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/ital /sician	o Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	✓ ER/Outpati		Other		ng Home 5	Residence 6	Other:	
of \ing Phy	-	27. Manner of Death		ite of Injury nth, Day,Year)	28b. Time	of Injury 28	sc. Injury at V	Vork?	28d. Describe	how injury occurre	ed	
Sion Attendidated:	catio	2 Accident Inv	estigation Fnd	6/23/08	Fnd 9		ı —		28f. Location	(Street and Number	er or Rural Route	Number, Ci
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		20a Certifier	Physician: To the base	pest of my know	ledge, death of	curred at the t	ime, date ar	id place, an	d due to the cau	use(s) and manner e and place, and d	as stated. ue to the cause(s)
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1		30. Name and address of person	n who compréted c	ause of death (Item 23a		Delik		1201			
		Zabiullah Ali, M.D.	Assistant Med	dical Examination Registrar's Signature		enn Street	, Baitimo	re, MD 2		MANE		
S Regis	tate stra			w B	Anna					OME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008

		•	For State of Maryland / Dept. 1 - State Registrar Ce.	rtificate of De	eath	Re	2008	21601				
Ì	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Michele J. Civan			2. Date of Death Month June 1	6 • 2008 Year	3. Time of Death 811 P M				
	Examin		4a. Facility Name (If not institution, give street and number) 8516 West Howell Road	4b. City, Town, or Loc Bethesd	la		4c. County of Death Montgomery	7				
L	Funeral Director		5. Social Security Number 085-38-1869 6. Sex 1 M X F 59 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, (arch 5,	Year) 1949 Nev	place (State or Foreign of York, NY				
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			1	0d. Inside City Limits				
	e Mary Ba-f sh	ctor	MD Montgomery Bethese					1 X Yes 2 □ No				
	th with th	Funeral Director	8516 West Howell Road	10f. Zip Code 20817			g. Citizen of What Cour United Stat	•				
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mydical Examinat must be motified at once.	þ	1 □ Never Married 2 ➡ Married 1 □ Yes 2 ➡ No	Was Decedent of Hispa If Yes, specify Cuban, M 1 □Yes 2 XNo <i>S</i>	anic Origin? (Spec Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: W					
215-(thin 72 he ie. ian "natu Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupatior kind of work done durin DO NOT use retired)	n ng most of working	g 1	6b. Kind of Business/In	dustry				
21	Hygien Hygien ther th	ပိ	17. Father's Name (First, Middle, Last)	eacher 18	, Mother's Name	(First Middle M	Education					
lano	fental ked of	To Be	Harry Burtoff		Pearl Si							
lary	and N is mar		19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ng Address (Street and				Code)				
و. ک	t and 2 Health Sm 27 ther tr			6 West Howe	ell Road		a MD 20817 Oc. Location - City or To	nwn Stata				
Baltimore, Maryland 21215-0036	tment of I tant: If ite		4 Donation 5 Other (Specify) Parklawn	osition (Name of matory or other place) Memorial Pa	ark 6/19	9/08 R	lockville, N	MD				
Bai	permit Depar Impor any in once.		21. Signature of Euneral Service Licensee D	2. Name and Address of anzansky-Go II/O Rockvi	f Facility Oldberg 1 LIIe Pike	Memorial e Kockvi	Chapels I	32				
5		cal Examiner	23a. Parf 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of):									
O. Box	death ce	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delive	ery Day Year				
ds, P.	res th	Š	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in	n Part I.		ie. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 1 Unknown					
Hec The law ate has t		Completed				24a. Was an autopsy perform 1 □ Yes 2	ed? prior to co	opsy findings available impletion of cause of				
Vital	Physician; r this certific ral director, I	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	_ Other:		ath (Check only one)						
on of	Attending Phy r death. ector: After this by the funeral d	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	f 28c. Injury at Work?		8d. Describe how	nce 6 ⊡Other <i>(Speci</i> v injury occurred	<u>yı</u>				
Division	al or Attences after death	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stee building, etc. (Specify)	eet, factory, office	2.	8f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,				
		Medical (29a. Certifier Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, ovestigation, in my opinion	date and place, a on, death occurre	and due to the ca ed at the time, da	use(s) and manner as te and place, and due t	stated. o the cause(s)				
	1 1	ž	29b. Signature and title of cartifier Nonere Mulle Man	29c. License nu D64615	umber		d. Date signed (Month, ine 17, 200					
	15		30. Name and address of person who completed cause of death (Item 23a) (Type,									
	Stat	0		Piccard Dr	rive Roc	kville M	1D 20850					
	Registra		31. Date filed (Month, Day, Year) 9 2003 32. Registrar's Signature	(posts								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04857 2008 21602 State of Maryland / Department of Health and Mental Hygiene Henry Eugene Chambers Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0900 hrs June 24, 2008 ¬I Examiner Henry E. Chambers, Jr. c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury 200 Winterborn # 7 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (in yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months Country) 1973 Feb 28, Director 2 217-78-5105 1 X M 35 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No MD Salisbury items 23a or 28a-f show 1st be notified at once. Wicomico Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21801 USA 200 Winterborn #7 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Orlgin? (Specify Yes or Nouneral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married 2 Married Yes Specify: Black Yes 2 X No specify: If Yes, Give Year 4 Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pernit. Pages I and 2 should be filed within 72 hours:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natura injury or other traumantic event, the Medical Examinium? during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Carpet Cleaning Receptionist Baltimore, MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl M. Kelley Henry E. Chambers, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ို Henry E. Chambers, Sr./father 10306 Dinges Road, Berlin, MD 21811 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 6/28/2008 Berlin, MD New Bethel UMC Cem Donation 5 Other Specify: ervision 22. Name and Address of Facility
Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 21801
se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21. Signatu Juneral Servi icen Approximate Interval 23a. Part I. Priner the disp **Physician** Between Onset and failure. List only the cause on each line Death *fledical* Cocaine intoxication Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and -G881 as noted, 23a, PII, 27, 28a-f, perME, 7/15/ Physician/Medical X AMENDED X UNPENDED physician the burial -The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth signed by the attending be detached for use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I Part II. Other significant conditions P.O. Yes 2 No 3 Probably 4 ✔ Unknown ð End stage renal disease Completed 24b. Were autopsy findings available 24a. Was an Records, prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes page. certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year 27. Manner of Death After Certification: unk Yes 2 X No Natural 5 Pending Fnd 6/24/08| Fnd 9:00 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be or Town, State)
200 Winterborn #7 Salisbury, Mi 3 Suicide (Specify) Found in residence 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director:
completely filled in by the f

> Melissa Brassell, MD 2008

Brand

29b. Signature and title of certifie

Assistant Medical Examiner egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 25, 2008

State Registrar

			1 - State of Maryl	and / Depa <i>Cer</i>	artment of He rtificate of D	ealth and Me <i>eath</i>	ental Hygie Reg.	ne 2008	21603
	Physici		1. Decedent's Name (First, Middle, Last) Donald L. Crist, Sr.				2. Date of Death Month June 1:	Day 2008	3. Time of Death 11:48 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or L Annapo.			4c. County of Death Anne Arun	
	Funeral Director		220-66-5854 ¹¾M 2□F 52	yrs, last birthday) Yrs.		If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Ye Mar. 28,	9. Birth 1956 Mary	place (State or Foreign ntry) Land
	Aaryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County 10c MD Anne Arundel 10c	Edgewat					10d. Inside City Limits 1 ☐ Yes 2 No
	with the N 3a or 28a-i	Funeral Director	10e. Street and Number 1618 Havre De Grace Drive		10f. Zip Code 21037		"	Citizen of What Cou USA	ntry?
920	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notitied at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	'	Mas Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 1 No	panic Origin? (Speci , Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White Specify: W	
21215-0036	vithin 72 ho ine. han "natul e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	dent's Usual Occupati kind of work done du DO NOT use retired) ruck Drive	ıring most of working	7	ndependen	
	be filed ntal Hygi ed other event, t	To Be Co	12 17. Father's Name (<i>First, Middle, Last</i>) James Crist, Sr.		т -	18. Mother's Name (Ruth Da	First, Middle, Mai	-	
, Maryland	nd 2 suith ar 27 is r trau		19a. Informant's Name/Relationship (Type. Print) Donald L. Crist, Jr./ Son	108 H	ng Address (Street an	Centrev	ille, MD	21617	
Baltimore,	t. Pages tment of tant: If it		4 □Donation 5 □ Other (Specify)	Meadowrid	sition (Name of matory or other place) dge Memori Park	al June 2008	19, E	Location - City or T	Maryland
Bal	permij Depar Impor any Ir once.		21. Signature of Funeral Service Licensee	B 49	arranco & 95 Gov. Ri	Sons, P.A tchie Hwy	. Severr	na Park Fu na Park, M	neral Home D 21146
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e	ic Ly	er the mode of dying,			,	Approximate Interval Between Onset and Death
D.	# 36	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause indexth) between the cause of the caus						
8760,	cate be executed oblysician and the burial-transit	dical Ex	resulting in death) Last Due to (or as a cond	nsequence of):					
O. Box 6	No signature of the past 12 months? Solution Solut							23d. Date of deli	very Day Year
Δ.	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but no	cco use contribute to	the cause of death?				
Vital Records,		Completed					24a. Was an autopsy performe 1 Yes 2	d?// prior to death?	opsy findings available ompletion of cause of 2 ☐ No
or Vita	yslclan: s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury	2 PA/Outpatier 28b. Time o	nt 3□ DOA Other	4 Li Nursing Hom		e 6 Other (Specialism occurred	ify)
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or	Certification:	Month, Day Yes 2	ar) Injury At home, farm, str	Mork?	es 2 No	Bf. Location (Stree	et and Number or Ru	ral Route Number,
Ö	spital or ours after neral Dire		4 ☐ Homicide building, etc. (S) 29a. Certifier 1 ☐ CertifyIng Physicien: To the best of my		h occurred at the time	e, date end place, a	City or Town, S		stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier			number	d at the time, date	and place, end due	to the cause(s)
	1		Jeanne Ween M.		25	2830	J	une 13,2	8008
	do	J .	30. Name and address of person who completed cause of death Teaune were 900 Bash 31. Date filed (Month, Day, Year) 32. Registrar's,	(Item 23a) (Type,	ocal#300	Annap	DXIS, M.	une 13,2 0 2140	/
DH	Sta Registi IMH 17 Rev 1/2	rar	30. Name and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild completed cause of dealing and address of person wild complete cause of dealing and address of person wild complete cause of dealing and address of person wild complete cause of dealing and address of person wild complete cause of the person wild complete cause of the person wild cause of t	· H A	fort				

Irene May Crislip TUNE 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GIEN BURNIE BALTIHORE WASHINGTON HEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2**X** F 87 Director May12,1921 175-30-4360 Usual Residence of Decedent 10a. State 10b. County death with the Marylan 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evanciaer must be notified at once. **Funeral Directo** Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 313 Hospital Drive 21061 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) PRISCIP IRENE 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No ģ Specify. 3 ₩idowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamtress 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William S. McDaniel ဂ Annie C Shull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin W. Crislip 554 2ND Street, Gambrills, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-1-08 Stahl Mennonite Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Marzullo Funeral Chapel, P.A 6009 Harford Road, Baltimore, Maryland21214

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NUSAIREE, HIRZA H.D. 31. Date filed (Month, Day, Year)

1401 HADISON PARK

Registrar's Signature

Physician /Medical Examiner 1 - For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, $\mathcal L$

1	-	F	-		4
ertification: To Be Completed by Physician/Medical Examine	nysician/Me	eted by PI	Comple	To Be	ertification
In by the funeral director, page 2 should be detached for use as the burial-transit	sched for use as	nould be deta	ır, page 2 s	al directo	d in by the tuner

Medical

23a. Part 1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the dea one cause on each line.	th. Do not enter the m	ode of dying, such as cardi	ac or respiratory arres	Interval Between	
Immediate Cause (Final disease or condition resulting in death)	. Coronar	ux anle	ry diseo	vo	Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of Due to (or a) Due t	quence of):	1		may you	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al déath 3 🗆 Ectopia	c pregnancy (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.		cco use contribute to the cause of death?	
				24a. Was an autopsy perform	24b. Were autopsy findings availated prior to completion of cause death? No 1 □ Yes 2 □ No	
25. Was case referred to medical examiner?						
1 ☐ Yes 2 🗷 No		■ ER/Outpatient 3 □	DOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 ☐ Other (Specify)	
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	28d. Describe how	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		nome, farm, street, factorify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a, Certifier 12 Certifying Pl (Check only 2 Medical Example)	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and pla on, in my opinion, death oo	ce, and due to the car curred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)	
29b. Signature and title of certifier		2	9c. License number	19 296	1. Date signed (Month, Day, Year)	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2

Certificate of Death

21604

3. Time of Death

108 PM

Birthplace (State or Foreign Country)

Pennsylvania

10d. Inside City Limits

1 □Yes 2X No

Reg. No.

Year)

U.S.A.

2008

4c. County of Death

AA COUNT

10g. Citizen of What Country?

Race - American Indian, Black, White, etc.

Specify: White

Garment Factory

20c. Location - City or Town, State

Tire Hill, PA.

16b. Kind of Business/Industry

2. Date of Death

State Registrar

B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SAMUEL WILLIAM CARTER Month Zcol **Physician** une /Medical 4c. County of Death
WASHINGTON 4a. Facility Name (If not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death HAGERSTOWN WASHINGTON COUNTY HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F 59 7/16/1948 493-52-6773 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at HAGERSTOWN MD WASHINGTON 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9871 CROSSFIELD ROAD 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married WHITE 1 ☐ Yes 2XXNo Specify. ò Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HORSE RACING Elementary/Secondary (0-12) College (1-4or 5+) HOT WALKER permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other if any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EZRA CARTER MYRTLE VIRGINIA CARTER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9871 CROSSFIELD RD., HAGERSTOWN, MD 21740 JAN LESLIE CARTER/SPOUSE 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JUNE 2008 SMITHSBURG CREMATORY SMITHSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) P.O. BOX 838, CHARLES TOWN, WV 25414 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNERAL HOME, Drown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Doeth Immediate Cause (Final disease or condition resulting in death) **Physician** ancre /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of); Examine burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 🔲 Yes 2 No 11 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760 certificate be Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

72

and physician attending properties of the second page 2 s certificate After n 24 hours after death.

The Funeral Director: A pletely filled in by the fu

10

Registrar

State

Medical

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 3 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D58853 AST ANTIETAM STREET HAGERSTOWN MP 21740

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HABIB 31. Date filed (Month, Day, Year)

4 ☐ Homicide

29a. Certifier (Check only one)

CHOTANI

251

To the within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE Month Day CLARKSON 18:56 M 18 TIFFAHY 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital **Baltimore City** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number Country) 25 September 30, 1982 229-65-221 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No YNCHOURG VIRGINIA 10f, Zip-Code 10g. Citizen of What Country? 10e. Street and Number 24503 U.S. A BRITAIN New 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) School STUDENT 12 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) BARRY AM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY LYNCHBURG, VIRGINIA 24503 New BRITAIN DRIVE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State FOREST, VIRGINIA Memorial PARK JUNE 23, 2008 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HER: TAGE FUNERAL Service AND CrempTery Dawey 427 GRAVES MILL Rd. LYNCHOURG, VIRGINIA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Herniation Brain Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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ral", or items 23a or 28a-f sho Examiner must be notified at

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or other traumatic

Department of I Important: If Ite any injury or of once.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

Examine the burial-transit by Physician/Medical ed by the at detached f signed to Completed funeral director, Be ဂ္ Certification: t hours after death.

uneral Director: After the full of the full within 24 hours after
To the Funeral Direct
completely filled in b

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

•	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of pregr 1	tal death 3 Ectopic			23d. Date of delivery Month Day Year	
Part II. Other significant conditions	contributing to death but not re	esulting in the underlying	g cause given in Part I.		se contribute to the cause of death? No 3 Probably 4 Dunknown	
				24a. Was an autopsy performed? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
25. Was case referred to medical						
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 MInpatient 2	☐ ER/Outpatient 3 ☐ D	ome 5 Residence	(Check only one) e 5 ☐ Residence 6 ☐ Other (Specify)		
27. Manner of Death 1 V Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred	
3 Suicide 6 Could not 4 Homicide determine			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Physician: To the best of my knoaminer: On the basis of examine and manner stated.				and manner as stated. If place, and due to the cause(s)	

5

State Registrar

Medical

31. Date filed (Month, Day, Year)

LI-MEI

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIN

29c. License number

RES-000

29d Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2008

JUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** $\underline{\underline{A}}^{\mathsf{M}}$ Jean Allen Dornin June 20 2008 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23630 Town Creek Drive Lexington Park St. Mary's 5. Social Security Number 6. Sex If Under 24 Hours 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗓 F 282-14-7832 Director 86 02 /24/1922 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20653 23630 Town Creek Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rodney Wallace Allen Olive Mae Holcomb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert William Askey / P.O.A P.O. Box 662 Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre June 20,08 Charlotte Hall, MD. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heart month s /Medical Due to (or as a consequence of): **Examiner** Cardiomyopathy
Due to (or as a consequence of) VeaR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours af

To the Funeral D

completely filled i 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1000

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 3 2008

Jude

Colleen D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

June 20, 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 3. Time of Death 8:24 P M 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Thomas Mitchell Dillow, Sr. June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 43616 Dillow Farm Lane St. Mary's Hollywood If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 29,1926 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In vrs. last birthday) **Funeral** 81 216-22-3063 Director Usual Residence of Decedent nd 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland St. Mary's Hollywood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 43616 Dillow Farm Lane 20636 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Alfred Dillow, Sr. Roberta Goldsborough ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 27 Patricia VanSise Dillow / Wife 43616 Dillow Farm Lane, Hollywood, Maryland 20636 permit. Pages 1 a
Department of Hec
Important: If Item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State St. John's Cemetery July 2, 2008 Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Matting Ley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LVNE CANGER METASTATIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year in the past 12 months? 1☐ Yes 2☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown icate has been siç , page 2 should b Completed CHRUMC RENAL TAILVAC 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate ! 1□ Yes After this certification, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Yes 2 No To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 11 Natural 2 ☐ Accident Injury To the Hospin...
To the Funeral Director: Aftrically filled in by the fur 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier DB 096 6-30-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20836 HUNNWOOD -A PBINDER GILL

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g883 9-4-08 vt State of Waryland 3/08 JH Certificate of Death

*5 Per FH g884 10/03/08 JH Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 18 Year Month **Physician** 2008 JUNE Elizabeth Dawson Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Nicomico MEDICAL SALISBURY REGIONAL TENINSULA CENTER 5.23 ial Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Virginia **Funeral** Days Hours Months 1 □ M 2 🕅 F 11-28-1925 331-26-9048 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2X No Director Salisbury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 1017 Adams Avenue, Apt. A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married ŏ 1 ☐ Yes 21 No Specify: White <u>ک</u> 3 X Widowed 4 □ Divorced "natural" Completed Health and Mental Hygiene. em 27 is marked other than "natur ither traumatic event, I're Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) University Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nowitski Marjorie ဥ Bernard Chitty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27025 N. Tourmaline Drive, Hebron, MD 21830 other t <u> Joan Elliott – daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition if it 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 6-20-2008 Delmar, Delaware Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home Signature of Funeral Service Licensee Her 705 E. Main Street, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or correlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician neumania disease or condition resulting in death) /Medical Due to (or as a consequence A) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 ☐ Yes 2 No 1 ∐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes VINO Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, ..al or Ah.
.ours after deau.
.ul Director: Aı.
.'in by the furwithin 24 hours

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Medical YZY

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 63/99. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHURE DR, SALISBURY, MD. VOHRA 614

State Registrar 31. Date filed (Month, Day, M 2008

(Check only

OGESH

strar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician /Medical Examiner

3altimore, Maryland 21215-0036

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After this

For Amend Item 10c State of Maryland / Department of Health and Mental Hygiene Registrar11,18,19b WCHD/SH 6/23/08FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dunkleberger Month Year **Physician** Dorothy 6:25 PM M June 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, May 19, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2**X**□ F 78 1930 **Director** Pennsylvania 186-24-7741 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he published and once. 10b. County rania Cumberland 10c. City, Town or Location
-Carlisie 10d. Inside City Limits Pennsylvania XXYes 2 □ No Director CARLISLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17013 151 Shughart Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. + Never Married 2 Married 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: X No 1 ☐ Yes 💥 No Specify. ٥ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be -Araminta Scicler Araminta Seidler William Robert Jones 2 19h Mailing Address (Street and Number of Bural Pout of Number of Grant Process of Shughart Rd., Carlisie, Pennsylvania 1 19a. Informant's Name/Relationship (Type. Print) Pennsylvania 17013 Robert D. Dunkleberger (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗶 Burial 2 □ Cremation 3 🗶 Removal from State Monroe Twp., Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 6/16/08 21. Signature of Funeral Service License Paul T. Lochstampfor M-00849 ²²Name and Address of Facility Uneral Home, Inc. 48 S. Church St., Waynesboro, PA 17268 whenplot 23. Part1. Enter the disease, or complications that cause d he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each key. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis 3 days disease or condition resulting in death) Due to (or as a consequence of): 3 weeks Acute renal tailure Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transi Fasciitis Necotizing Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 MrNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 X No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No P 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral [1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62603 MD 9,2008 Jun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Baltimore Maryland 21201 Eric Schmidt MD 1H-10 Univ. 22 South 31. Date filed (Month, Day, Year)

JUN 2 3 2008 32. gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

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an Michael De		orff State of Maryland / Department of Health	n and Menta	al Hygiene		2008 2161
		- For State Certificate of Death			Reg. No.	3. Time of Death
Physicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of De Month June 26,	Day Year	
dical Examin	_	Ryan Michael Deardorff	own, or Location of		4c. County o	
		tal. I dointy Name (in not moutation, give on the control of the c		Death	Carroli	1 Doddi
		25 S. Cranberry Road		Odles 19 Date of F		9. Birthplace (State or
Funeral		5. Social Security Number 220–21–1989 6. Sex 7. Age (In yrs. last birthday) Months	Days Hours	T		Foreign
Director		220-21-1989 _{1x M 2 F} 26 _{Yrs.} Wolfins	,	04/10	/1982	CountMaryland
	Ì	Usual Residence of Decedent		1	<u> </u>	10d. Inside City Limits
any		10a. State 10b. County 10c. City, Town or Location				1 Yes 2 No
nd show	٦	Maryland Carroll Taneytown			10g. Citizen of Wh	
aryla 8a-f	섫	10e. Street and Number 10f. Zip	Code		10g. Citizen of win	nat Country?
he M	Director	21 George St.	21787		USZ	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygerian. Inportant: If item 21 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ones, injury or other traumatic event, the Medical Examiner must be notified at ones.	ā		nt of Hispanic Origi	in? (Specify Yes or I Puerto Rican, etc.)	No- 14. Race White	e - American Indian, Black, e, etc.
item item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify 1 Yes 2 X No	y Caban, Moxican,	, acito traca, and		
ter d ", or er m	E	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	No specify:			White
urs at tural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual during most of wor	Occupation (Give k	kind of work done	16b. Kind of Bu	usiness/Industry
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od wi	Cor	17. Father's Name (First, Middle, Last)		's Name (First, Middl))
215 215 se file stal H ked o	Be	Michael Allen Deardorff	Juc	dy Lynn Bo	ston	Otata Zia Cada)
Z1 bulld bulld bul	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address				vn, State, Zip Code)
MD 2 sho 27 is amat		Judy Lynn Howard/Mother 21 George			D 21/8/	- City or Town, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It liters 12 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Nat crematory or other place	ne of cemetery,	Date	20c. Location	- City of Town, State
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Bal perm Depa Impe	1	1 412 W	ashingtor	Rd. Wes	stminster	. MD 21157
	_	5 who disease a smallestone that caused the death. Do not enter the mode	of dying, such as c	cardiac or respiratory	arrest, shock, or he	eart Approximate Interval Between Onset and
Physician Medical		failure. List only one cause on each line. Methadone intoxication Immediate Cause (Final disease a.				Death
aminer		Immediate Cause (Final disease a				
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	F	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause		7		
.	xar	events resulting in death) Last Due to (or as a consequence of):				
and and trans	calE	d				
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Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		ic pregnancy	23d. Date of Month	
687 ertific ding e as t	an	past 12 months?		ne pregnancy	(i)	
ath co	Sici	Pregnant at time of death 5 Other (Sp 1 Yes 2 No 9 Unknown 9 Unknown	ecity)		-	
he de / the	چ	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in F	Part I. 23e. [Oid tobacco use cor	ntribute to the cause of death?
P.O. es that the igned by be detach	2			1	Yes 2 No	3 Probably 4 V Unknown
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rd; v requ	lete				autopsy performed?	prior to completion of cause of death?
e lav te has	Completed				res 2 No	1 ✓ Yes 2 No
Division of Vital Records, and or Attending Physician: The law requirers after death. Director: After this certificate has been size in by the funeral director, page 2 should it.	၂ ပိ		26.Place of Deatl	h (Check only one)		
ital iciar s cen	å	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other	Nursing Home	Residence 6	Other: Scene
Physer this	٢	1 V Yes 2 No 27 Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Wo	ork? 28d. Desc	cribe how injury occ	urred
ding ding	5	(Month, Day, Year) 1 Natural 5 Pending Fnd 6/26/08 Fd 12:30	1 Yes 2 🛚	No land		
SiO vitten deatl deatl	1	Pending Investigation Investig	JIII ory, office building,	etc. 28f. Locat	tion (Street and Nur	mber or Rural Route Number, City
ivi	Certification:	3 Suicide 6 X Could not be determined (Specify) found in mote.		25 °ST°	wn State) Cranberi	Westminster, MD ry Rd
D spital sours neral	ة ا	4 Homicide (Specify) TOUTIGETTI INC. E.				
Division of Vifal Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and comminent of filled in white fineral director, page 2 should be detached for use as the burial - transit	2 2		my opinion, death	occurred at the time,	date and place, an	id due to the cause(s)
Fo the vithin Fo the	Modical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	29c. License numbe			signed (Month, Day, Year)
	ĺ	29b. Signature and title of certifier		<u>.</u>	June 27,	
WIL		tate lever - Volor -	O.C.M.E.		Juile 27,	, 2000
0		30. Name and address of person who completed cause of death (Item 23a)				
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111	Penn Street, F	Baltimore, MD 2	1201	
	Stat	32 Pegistrar's Signature				
Reg		HIND O COCO He - Me Man Me				
		OFICINAL				
HMH 17 Rev 1	1/200					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 12:18 2668 4he artin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth (Month, Day, Year) 7/15/1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 341-16-6870 86 XXM 2 F Illinois Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a. State 10b. County 1 X Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be USA 524 N Charles # 1204 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 2 should be filed within 72 hours after or and Mental Hygiene.

Is marked other than "natural", or ite 1 Tyes 2 No WWII
If yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No White 3 Widowed 4 □ Divorced Specify. <u>\$</u> Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Appliance Store Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pear1 Stauffer Sadie Walter DeMoulin permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any linjury or other traumatic eviouse. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224-A Scotts Manor Court Odenton, MD 21113 Michele Fulk Daughter 20a. Method of Disposition
1 → Burial 2 → Cremation 3 → Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Mulberry Grove CEM. Mulberry Grove IL. 6/19/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD 21. Signature of Funeral Service Licensee Vatu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** osterio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the att 2 🗆 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Tes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28d. Describe how injury occurred

Box 68760 P.O. Division of Vital Records,

the Hospital or Attending Physician: The Ahours after death.

the Funeral Director: After this certificate I completely filled in by the funeral director, Certification:

29a. Certifier (check only one)

Medical

State

Registrar

1 Natural

2 Accident 3 Suicide

6 Could not be determined 4 T Homicide

5 Pending investigation

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work?

1 🗌 Yes 2 🗌 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

> 29c. License number RES-000

29d. Date signed (Month, Day, Year) 2008

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Haine navle 31. Date filed (Month, Day, Year) JUN 17 2008

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

within 2 To the

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Marylant		tificate of		nemanny	Reg. No. 2	800	21614
н	Physici	an	1. Decedent's Name (First, Middle, Last) Margaret Rose	Dutkowski				2. Date of De Month	Day	Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, give s			4h City Town o	Location of Death	June 1		of Dooth	11:00 A M
1	Examin	ier	6333 Bell Station			Glenn Da			4c. County of Death Prince George's		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, D			lace (State or Foreign
	Director		393-10-0293	lm 2∏F 87	Yrs.	Wionuis Days	TIOUIS WIIII.		29, 1921		consin
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				16	0d. Inside City Limits
	Mary 3-f sh	tor	Maryland Prince G	eorge's Gla	enn Da	1e					1 □Yes 21X1 No
	th the	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	ath wi	ral	6333 Bell Station	Road		207			U.S.A		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ith Medical Experiment institute relified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 🗓 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:	1	Vas Decedent of H Yes, specify Cuba □Yes 2XN No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify	e - America ck, White, e	
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d 2	filed v Hygid Sther ent, II		17. Father's Name (First, Middle, Last)		110001		18. Mother's Name	e (First, Middle			
<u>la</u> n	Ald be Alental rked of tic ev	To Be	Emil Radtke				Elsie M	larquar	dt		
lary	shou and N is ma	Γ,	19a. Informant's Name/Relationship (Type	oe. Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Numb	er, City or Town,	State, Zip	Code)
≥,	and 2 lealth m 27 her tr		Denise Jeanne Jack								land 20769
Baltimore,	ges 1 nt of H if ite or otl	3	20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re			ition (Name of atory or other place		Date	20c. Location -	•	,
Itim	nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Veterans					Maryland
Ba	Department of the position of		900-7-Kun	ζ			ss of Facility Rob polis Roa				
П			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.		•	20.0000 0000	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		roho	ury wr	tery 1	>, sea	re		"ylles"
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68760,	rificate be executed ng physician and as the burial-transit	Physician/Medical	d.							+	
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M	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal of 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)	/ 		Мо		Day Year
P.O.	at the	Phys	9 Unknown								
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sio	tendine eath.	catio	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No				
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		Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowler: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s) and ma	nner as st	tated. the cause(s)
	To the within To the somple	Me	29b. Signature and title of certifier	Sand Francisco States		29c. License	number		29d. Date signed	Month, I	Day, Year)
	1) David/	Year te)	TGO .	5	17572	2	61	1/2/	/mf
	PO	R	30. Name and address of person who cor	npleted cause of death (Item 2	23a) (Type, P	rint)			1		
	Ma		1). g. vanit			Jerce	cay S	recu	helt, a	MO	20770
	Stat	е	31. Date filed (Month, Day, Year)	32. Pegistrar's Signatu	le .	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year June 14, Physician 423 АМ Louise P. Durham AKA Louise Catherine Durham /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year)
Dec. 26,1920 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🗓 F 87 Yrs 577-24-0482 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location nd Mental Hygiene. . marked other than "natural" or items 23a or 28a-f show umatic event, It a Modical Examination to modified at 10a. State 1 TYYes 2 □ No Director MD Bowie Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20716 USA 15429 Neman Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 →No altimore, Maryland 21215-0036 Specify. Specify: Black ğ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bureau of Engraving & Elementary/Secondary (0-12) College (1-4or 5+) Printing Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental John N. Proctor Elizabeth V. Harley 27 is marked traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sylvia Durham/ Daughter 15429 Neman Drive Bowie, MD 20716 permit. Pages 1 and Department of Health Important; If item 27 any Injury or other troopie. 27 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 6/18/2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Emeral Service Licens 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) /Medical Due ! (or as a consequence of): **Examiner** atheroseheren Source trally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical the as attending properties of IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? certificate 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 124 hours after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 12:30 Physician June 2008 Anna Marie Ellis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's California 23116 Three Notch Road 8. Date of Birth (Month, Day, Year If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2XF March 1, Maryland 62 114-40-5973 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗑 No California Directo Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20619 23116 Three Notch Road Funeral within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be es 1 and 2 should be fi of Health and Mental F fi**tem 27 Is marked ot**l Margaret Esther Faunce John Howard Forrest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23116 Three Notch Road, California, Maryland 20619 Paul Eugene Ellis / Husband permit. Pages 1 a
Department of Hes
Important: If item
a y injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hollywood, Maryland June 28,2008 St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licens P.O. Box 270, Leonardtown, Maryland 20650 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Onset and Death 23a. Paul. Enter the disease, or omplications that show, or heart failure. List only one of use on Immediate Cause (Final structive Physician hronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Chknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1 ☐ Yes I or Attending Physician: after death. Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Stesidence 6 Other (Specify) Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D62042 008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28103 Three Notch Road, Suite 101, Mechanicsville, Maryland 20659 Karen Bauer, M.D. 31. Date filed (Month, Day, Year) JUN 2 State 200B Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0718 A M 27 2008 **Physician** Evans June Μ. Lula /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 Elkton 511 Skipjack Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number Hours **Funeral** Months Days AUG 25, 1939 North Carolina 1 M 2 F 68 239-60-2882 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 1 X Yes 2 □ No E1kton Ceci1 Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 511 Skipjack Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Black Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cleora Armstrong Charles Higans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 511 Skipjack Court, Elkton, MD 21921 Edward L. Evans, Sr./Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

IVY Hill June 28, 20a. Method of Disposition 1 ☐ Burial 2 Xi Cremation 3 ☐ Removal from State <u>Philadelphia, PA</u> 2008 Cemetery/Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 21921 8-4 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final isea Le ovonery **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical year ardio My 0 **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burlal-transit certificate be executed Due to (or as a consequence of): Physician/Medical as 23d. Date of delivery for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death n signed by the a 1 ☐ Yes 2 ☑ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division or Vital Records. 2 certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an autopsy perform 2**X** No 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 1 Yes 2 No Medical Certification: To After this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) thours after death.

-uneral Director: A
ely filled in by the fu death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3☐ Suicide 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00059223 30. Name and address of person who completed cause of death (ILEN 23a) (Type, Print)

Melchore, Madarang, Mo 215 A 215 North Street, Elkton, MD . Registrar's Signature 31. Date filed (Month, Day, Year) State 03

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BRIAN DOUGLAS FREE 2008 June 3:28 A^{M} 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 | West High State of First | State of Birth | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of First | State of Fi 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ₩ 2 □ F 213-02-9628 40 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Carrol1 Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6328 Keysville Road 21757 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Tree Trimmer Tree Pruning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Edwin Free Linda Downs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9602-D Rocky Ridge Road, Rocky Ridge, MD 21778 Robert E., Free / Father 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ch. of the Brethren Cem. 6/23/08 Rocky Ridge, Maryland 21. Signature of Spheral Service Lie ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the dispar Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ncephalopan oahe disease or condition resulting in death) Due to (or as a consequence of): OMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cialosis Due to (or as a consequence of): LIVEL 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year □Yes 2□No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referre to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 □ Ippatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V atural 5 Pending 2 Accident

Physician /Medical Examiner

permit. Pages 1 and 2 shou d be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other the any lojury or other traumatic event, ITS and Bonce.

Physician

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Director

28a-f show

Director

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flled within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

sician and burial-tran attending physician for use as the buria

certificate be executed signed by the a director, page 2 should certificate After this filled in by the funeral Hospital or Attending death. hin 24 hours after deatl the Funeral Director:

Physician/Medical þ Completed Be Ď. Certification:

ca

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 27. Manne Death

investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b Signature an

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D-0054218 06-19-08

State Registrar

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31. Date filed (Month, Day, Year) JUN 2 3 2008

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Malenin chire, were runing MD 2/150 uneun egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Bernard George Fuller /Medical 2008 12:45P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges 8. Date of Birth (Month, Day, Year) Sept.11,1930 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 № M 2 □ F 077-22-4610 Director Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes ※No Director Maryland Charles Hughesville 10e. Street and Number 10g. Citizen of What Country? 14910 Mykinda Place 20637 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of the filed hand Mental Hygiene.
ant: If Item 27 is marked other than "natural", or ite Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21k No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Sergeant U.S.A.F. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Fuller Margaret Desmond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14895 Mykinda Place, Hughesville, MD 20637 Glenn Cross/Son-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If Ite
any injury or ot 1 █ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 6/30/2008 Cheltenham, Maryland 21. Signature of Funeral Service Lic BRINSFIELD-ECHOLS FUNERAL HOME, P.A. M00817 30195 Three Notch Rd. Charlotte Hall, MD 20622 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. | ☐Yes 2☐No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 🛣 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient s after death.

I Director: After this ce
of in by the funeral direc Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital o within 24 hours aft To the Funeral Di completely filled in

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

UNE CENTER, WALMENT UND, ZEEDE

31. Date filed (Month, Day, Year) JUN 24 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04891 State of Maryland / Department of Health and Mental Hygiene 2008 21620 Charles Michael Fitzgerald Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 25, 2008 0722 hrs ' Examiner Me~ Charles Michael Fitzgerald 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Carroll Westminster 547 Congressional Drive If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Country)Maryland 07/17/1951 Director 216-54-6629 1× M 2 56 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No Westminster Carroll "natural", or items 23a or 28a-f sho Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21158 547 Congressional Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 X Married 1X Yes Specify: White 1 Yes 2 X No specify: Divorced or Dates 1969-1971 3 Widowed \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) within 72 hours during most of working life. DO NOT use retired) Completed timore, MD 21215-0036

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trment of Health and Mental Hygiene.

rqan: If item 27 is marked other than "ns
y or other traumatit event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Insurance 2 Property Claims Adjuster 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Marie Strieb James Fitzgerald Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P 547 Congressional Dr., Westminster, MD 21158 Charlene Mae Fitzgerald/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, 1 X Burial 2 Cremation 3 Removal from State Evergreen Mem. Gardens 06/29/2008 Finksburg, Maryland Department of Important: Injury or oth 4 Donation 5 Other Specify 21. Signature of Funeral Service Licens Pritts Funerally Home & Chapel, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and physician failure. List only one cause on each line Death 1_{colica} Chest injuries Immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial AMSNEPII,27,28a-f, perME,G881 <u>7/7/08 TT</u> 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ð Pulmonary embolus due to deep leg vein thrombosis. Completed 24b. Were autopsy findings available 24a. Was an has been s 2 should l prior to completion of cause of Hypertensive atherosclerotic cardiovascular autopsy death? performed? certificate has 1 🗸 Yes 2 No ✓ Yes 2 No disease 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Division of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 DOA ER/Outpatient 3 1 🗸 Yes No 28d. Describe how injury occurred subject fell 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death out of window Certification: Yes 2 X No Natural Pending Director: d in by the 6/25/2008 Fnd 7:13 antn 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 547 Congressional Dr. Westminster, Could not be 3 Suicide (Specify) residence determined Homicide Certifying Physician: To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier WIL June 25, 2008 O.C.M.E. 0 30. Name and addr so of person who completed cause of death (Item 23a) OCME 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Mary G. Ripple MD. 32. egistrar's Signature 31. Date filed (Month, Day, Year) JUN 3 0 2008 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Aller 10:40 AM 2008 10 -rase /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10**X**M 2□ F Yrs Director 62008 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23s or 28e-f show the Madical Examiner must be notified at 1 ☐ Yes 2 12 No Director owns 10e. Street and Number 10g. Citizen of What Country? 21032 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ACM other traumatic event, permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 is marked oth ery july or other traumatic event one. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be lauton traser ၉ Dent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21032 Cransville 1570 rouns, 110 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 6/17/2008 Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Sery 12 ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician greentelming /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Be Completed by Physician/Medical Examiner Due to (or as a consequence of altending physicien and for use as the buriat-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has this certificete 2 1 No 1 Yes ours after death.

Neret Director: After this certification by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year, 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel [29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pkw. Suzanse DO 2001 Annapolis 31. Date filed (Month, Day, Ye 32. Registrar's Signature State Registrar

			For State	State of	Marylan		artment of			lental Hy	giene	0000	0.1	4.0
			Registrar			Cei	rtificate o	f Death			Reg. No.	2008		62
	Physici /Media		1. Decedent's Name (First, Middle, Betty Patri	,	ty					2. Date of Dea Month June	1 Day	2008 Year	3. Time of 11:00	
and the	Examir		4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town		of Death			4c. County of Death		
-			130 A Street 5. Social Security Number	6. Sex 7.	Age (In yrs.	lo at hirthday	Lothi		r 24 Hrs.	0. Date of Die		nne Arur		C
	Funeral Director		264 14 1941		88	Yrs.	Months Day		Min.	8. Date of Birt (Month, Da 08/11/	y, Year) 1919	Cour	place (State of htry) Ligan	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside Ci	ity Limits
	Mary a-f sh	żo	MD Anne	Arunde1	Lot	thian							1 □Yes	XX No
	th the	Direc	10e. Street and Number				10f. Zip Code)			10g. Citi	zen of What Cour	ntry?	
	ath w	ral	130 A Street				20711				USA			
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Martical Examinator must be notified at once.	by Funeral Director	Narital Status Never Married 2 Marrie Mwidowed 4 Divorced	12. Was Deceded Armed Force 1 XYes 2 If Yes, Give Year or Date	es? □No W	NTT	Was Decedent of f Yes, specify Co I □ Yes 2XN			ecify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.	
2-0	72 hou	eted	15. Decedent's (Specify only highest	s Education		16a. Dece	dent's Usual Occ kind of work dor	supation	ot of wark	ng	16b. Kir	nd of Business/In		
21215-0036	/ithin	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	OO NOT use reti	red)	SI OF WORK	ng	77	-1+1- C		
	illed w Hygie ther tl	S	17. Father's Name (First, Middle, L.	5+		Nurs	3e	18 Moth	ar's Name	(First, Middle,		alth Car	e	
Maryland	ld be fental ked o	To Be	Frank Bassett	asiy						h Willi		ourname)		
ary	shou and M s mar umat	۲	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	g Address (Stre	et and Numb	er or Rur	al Route Numbe	er, City o	r Town, State, Zip	Code)	
	and 2 ealth n 27 i		Peggy Wilson (d	aughter)		130	A Stree	t/Lotl	nian	MD 2071	1			
Baltimore,	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3	3 ☐ Removal from Sta	ate 20b. P	lace of Dispo emetery, cren	sition (Name of natory or other p	lace)		Date 0		cation - City or To	,	
Ħ	it. Par rtmen rtant: njury		4 □ Donation 5 □ Other (Spe	ecify)	Met		Ltan Cre	1-				xandria	VA	
Ba	permi Depar Impor any ir		21. Signature of Funéral Service L	Censee		Á	Name and Add dvent Fu nnapolis	ineral MD 2	"% C1 1401	emation	Svo	es		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or c shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or injury that initiated events	a Due to (or b	as a consequence	es +ion uence of):	er the mode of d		s cardiac o		rest,		Approximate Interval Bet Onset and I	ween Death
68760,	icate be executed physician and the burial-transit	dical Exar	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
O. Box	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ☐ Fetal nt at time of d	death 3] Ectopic pregna] Other <i>(specify)</i>				. 2	23d. Date of delive Month		Year
rds, P.	v requires that been signed t should be deta	þ	Part II. Other significant condition Piaketer	ns contributing to death	h but not resu	ulting in the ur	derlying cause (given in Part	Ι.	23e. Did to		se contribute to the	ne cause of d pably 4 □ l	
Vital Records,		Completed	- A/zheimers	Deme	ntea							24b. Were auto prior to co death? 1 □ Yes	mpletion of	available ause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					e of Death	(Check only o	ne)			
of	Phys er this eral dii	: To	1 ☐ Yes 2 ☑No 27. Manner of Death	28a. Date of I		ER/Outpatien 28b. Time of	1 3 LI DOX			me 5 Resid		Other (Specif	y)	
ion	Attending Ph r death. ector: After th by the funeral	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	1	Day, Year)	Injury	28c. In W M 1	ork? □Yes 2□						
Division		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of building,	Injury - At ho etc. (Specify	me, farm, stre	eet, factory, office	Э		28f. Location (S City or Tow	treet and n, State)	d Number or Rura	l Route Num	ber,
Ω	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying	Dhariston To the he		tedie de de								
	To the Hospital within 24 hours a To the Funeral C completely filled	ledical	(Check only one)	Physician: To the be xaminer: On the basi and manner	s of examinat	wiedge, deatr tion and/or inv	estigation, in m	time, date a y opinion, de	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manner as a place, and due to	tated. the cause(s	·)
	To the within To the Comp	Me	29b. Signature and title of certifier	() 1			29c. Lice	nse number			29d. Date	e signed (Month,	Day, Year)	
	N-11-		/ Menus C	weet			1	7310	602	/	41	14/8		
	NOW!	M	30. Name and address of erson wi	ho com ded cause o	of death (Item	23a) (Type, I	Print)					20716		
	Sta	to	31. Date filed (Month, Day, Year)	32 4 Redi	420/ strar's Signat	/ Mito	trell Vill	e Ref	1.	Powie,	Md	20716		
	Registra			008	m d	X de	hell vill							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AFND TIPM Deriff C881 7 2 08 W. State of Maryland 1 Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $6/2\overset{\text{Day}}{2}/2008$ Physician 10:50 AM Annabelle Gray Frazier /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dorchester Cambridge Mallard Bay Care Center 8. Date of Birth (Month, Day, Y 4/3/1925 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F Maryland 218-16-7721 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene. ant of Heath and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 1 MYes 2 No Director Cambridge Dorchester Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21613 USA 214 Meteor Ave., Apt. 804 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No White Specify: Specify. þ 3 MWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 11 Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mildred Gray Rannie Gray ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2013 Church Creek Rd., Church Creek, MD 21622 Carol Pritchett/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Department of Important: If any Injury or once. 6/25/2008 Cambridge, MD Dorchester Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21/Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) met astatic adenocarcinema **Physician** /Medical Due to (or as a consequence of) Examiner rinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Home 2010 1 | Inpatient 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

8

Registrar

State

31. Date filed (Month, Day, Year)

3 2008

100 Bramh

32. Registrar's Signature

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

			1- State of Maryland / Deposition of the State of the State of Maryland / Deposition of the State of the		negritor L T C L
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year 3.05
	/Medie	al	Teresa Mae Gray	June	24, 2008 P ···
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
- 8		W-	38468 Laurel Ridge Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Mechanicsville If Under 1 Year If Under 24 Hrs. 8 Date of	St. Mary's Birth 9. Birthplace (State or Foreign
EX.	Funeral Director		216-22-2511 1 M 2 K F 83 Yrs.	Months Days Hours Min. Januar	Birth Day, Year) 9. Birthplace (State or Foreign Country) 4,1925 Mary Land
	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lo	cation	10d. Inside City Limits
	Maryli f sho ied at	ro		csville	1 □Yes 2 No
	r 28a- notif	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h with		38468 Laurel Ridge Court	20659	USA
õ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes Give A	Nas Decedent of Hispanic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 21/21 No Specify:	Black, White, etc.
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Ian	uld be Menta rked ric ev	To B	Charles Edward Flora	Cora Pilkerto	n
Maryland	2 sho and h is ma			g Address (Street and Number or Rural Route Nu	
	and lealth m 27 her tr	Ŷ		aurel Ridge Court, Mechanics	
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	iit. Pa artmer ortant: injury		4 Donation 5 Other (Specify) 21. Signature, of Funeral Semperation 2.	metery July 1, 2008 Name and Address of Facility Letting Ley	
n n	Depart Impo	5 5	Muchaeth Hardener P	O. Box 270, Leonardtown, Mar	yland 20650
			23a. Part Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respirator	y arrest, Approximate Interval Between Onset and Death
Ĉ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	tructive pulmonary	disease
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
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8/00,	icate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):		
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O. Box	To the Hospital or Attending Physician: The law requires that the death certifin within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
DIVISION OF VILAI RECORDS, P.	uires that i signed by d be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u		d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown
Š	w req	lete		24a. W	as an 24b. Were autopsy findings available
ב ב	hysician: The lav his certificate has I director, page 2 a	Completed		au	stopsy prior to completion of cause of death?
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	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	occurred at the time, date and place, and due to t restigation, in my opinion, death occurred at the tin	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	0		1/1/Som	D62042	6/25/2008
	1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	
	. 01		Karen Bauer, M.D. 28103 Three Notch Road, Sur	te 101, Mechanicsville, Mary	land 20659
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 6 2008 32. Figistrar's Signature	and the same of th	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Olato of me	x1 y 101.10	•	tificate of		Re	g. No. 2008	3 21625	
	Physicia		1. Decedent's Name (First, Middle, L Marie	ast)			Gladd	len	2. Date of Death Month	Day Year (9 200)	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, ga		•			r Location of Deat		4c. County of Deat	th	
				Sex 7. Age	e (In yrs. las	nill/	If Under 1 Year	<i>ALIS bU Y</i> I If Under 24 Mrs.	8. Date of Birth	3irth 9. Birthplace (State or Foreign		
	Funeral Director		221-14-2758	1 M 2 K F 7. Age	84	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Co	laware	
	iryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	he Ma 28a-f	Director	MD Wicomi 10e. Street and Number	.co	Ma	rdela	Springs 10f. Zip Code		10	og. Citizen of What Co		
	3a or	l Dir	11136 Sharptown	Road				1837		USA		
	ems 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. \	Vas Decedent of H f Yes, specify Cuba		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White		
215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show after Evalviting or nutilised at	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ∐Yes 2 N N If Yes, Give Year or Dates:	10		∐Yes 27∏ No	Specify:		Specify: W	hite	
<u>က</u>	"natu	letec	15. Decedent's E (Specify only highest g	Education rade completed)		16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	oation during most of wor	rking 1	6b. Kind of Business	'Industry	
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yland	2 should be and Menta is marked raumatic ev	ဥ	Ernest	G.		Carme		Madora		Gordy City or Town, State,	7in Cadal	
<u>a</u>	and 2 sh ealth and n 27 is n her traur		19a. Informant's Name/Relationship Joyce M. Eskridge		r					Springs. 1		
e,	of Hea		20a. Method of Disposition				sition (Name of natory or other place			20c. Location - City or		
Baitimore,	Pages Iment of tant: If its jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		1	Fello	ws Cemet	ery: 6-2	3-2008 L	aurel, De	laware	
Rall	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	j	21. Signature of Funeral Service Lice	insee Black	re.	1	. Name and Addre	ע		eral Home	and 21804	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List ont	nplications that caused	the death.	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death	
The same	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Artz	rios	scler	otic Co	proiora	scalar a	diregre	Oliset and Death	
	/Medical Examiner	M		Due to (or as	a conseque	ence of):						
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ras, r.	requires that the peen signed by th hould be detache	þ	Part II. Other significant conditions	contributing to death bu	ut not result	ting in the u	nderlying cause giv	en in Part I.		acco use contribute t s 2 □ No 3 □ F	/	
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	Physician: r this certifica ral director, p	ВеС	25. Was case referred to medical examiner?	Hannital:			Out		ath (Check only one			
	Phys this	<u>۲</u>	1 Yes 2 No 27. Man of Death	28a. Date of Inju	ry 2	28b. Time of	ot 3 DOA Oth	4 LI Nursing I	Home 5 ☐ Reside	nce 6 Other (Spewinjury occurred	ecify)	
loi 0	Attending r death. sctor: After by the funer	ation	1 ✓ Natural 5 ☐ Pending investigati		y, Year)	Injury		k? Yes 2 □ No				
DIVISION	al or Attend safter death I Director: v d in by the f	ertification:	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place of Inju- building, etc	ury - At hon c. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		Physician: To the best of aminer: On the basis of and manner sta	f examination							
	To the within To the comp	Me	29b. Signature and title of certifier	10 1			29c. Licens	se number	29	9d. Date signed (Mon	th, Day, Year)	
	Kan		1 4	Sul			D54	1807		6/19/08	3	
	- 2 g		30. Name and address of person when the control of	completed cause of d	P. R.	23a) (Type, M.C.	100 E. (arroll St.	Salisbu	ry, mD. a	21801	
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2008 32. Registra	ar's Signatu	ire &	Sport					

DHMH 17 Rev 1/2001

221-14-2758

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 8:52 P M June 2008 Gelfand Lottie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Williamsport Homewood at Williamsport Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔀 F 13,1922 New York **Director** 190-12-3549 85 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ant. If item 27 is marked other than "natural", or items 22a co 28a-f show up or other traumatic event, Ite Marical Examin at must be callified at 10c. City, Town or Location 10a. State 10b. County 1 ¥Yes 2 □ No Director Palm Beach Green Acres FT, 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 33463 6326 Silver Moon Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify Specify: White ģ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fabric/Textiles 8 th Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Elsenberg** Ida ၉ Louis Braunstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David L. Handler/Son-in-law 13507 Spring Hill Dr. Hagerstown, MD 21742 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or conce. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Eternal Light Mem. Gardens 6/24/2008 | Boynton Beach, FL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac St. Hagerstown, MD 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Immediate Cause (Final CICA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury Examiner Jua to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 Z No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28h Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of on who completed cause of death (Item 23a) (Type, Print) 17H-5 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		ir yrarra		tificate of l			Reg. No	2008		
	Physicia	an	1. Decedent's Name (First, Middle, Las						2. Date of Do	eath 16,	ay 2008	3. Time of 10:37	
	/Medic	al	HODELO HODEL	Goff			4b City Town or	Location of Death	June		c. County of Death		
ï	Examin	er	4a. Facility Name (If not institution, give		+01		Takoma I		•	Montgomery			
water or	Funeral	- 1	Washington Adven 5. Social Security Number 6. S	ex 7. Age	(In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth	9 Birth	nplace (State o	r Foreign
l	Director		579-22-4175 Usual Residence of Decedent	X M 2□F 8	2	Yrs.	Months Days	Hours Min.	5/26;	1926	VA		
	/land ow at		10a. State 10b. County		10c. City, T	Town or Loc	cation					10d. Inside Cit	
	Many a-f sh iffed	tor	MD Prince G	oerge's	Hyat	tsvil	1e					1X Yes	2□No
	th the	Director	10e. Street and Number				10f. Zip Code				itizen of What Cou	untry?	
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	er dez items ner m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puer	pecity Yes or N to Rican, etc.)	10-	Black, White		
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2	e. an "na Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done OO NOT use retired		King	_		E C., 1631	ation
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	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Last	,				1	a Unkno		in Sumame)		
2	2 should and Mer is marke aumatic	유	Buck Goff 19a, Informant's Name/Relationship ((Type Print)		19h Mailin	ng Address (Street				or Town, State, Z	in Code)	
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<u>=</u>	permit. Pag Department Important; any injury once.		21. Signature of Funeral Service Lice		10	22	2. Name and Addre	ss of Facility Ma				ie	
מ	De la la la la la la la la la la la la la		1 DP ONG	ushai	<u> </u>		217 9th				on, DC		
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	uted 1 ansit	Examiner	Se wentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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0	ng Pl		27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o Injury	Wo	rk?	28d. Describ	e how in	jury occurred		
<u>S</u>	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not to	De 280 Place of init	un/ - At hom	no farm sti	M 1 □ reet, factory, office]Yes 2 □ No	28f Location	(Street	and Number or R	ural Route Nui	mber.
Division or	after of Direct of in by	Certification:	4 ☐ Homicide determined		c. (Specify)		oot, ractory, ornec		City or 1	Fown, St	ate)		,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	Physician: To the best aminer: On the basis o and manner st	of examination	ledge, deat on and/or in	th occurred at the to	ime, date and plac opinion, death occ	ce, and due to the curred at the time	he cause ne, date	e(s) and manner a and place, and du	s stated. e to the cause	(s)
	To the To the Comple	Me	29b. Signature and title of certifier	(7)				se number		29d. I	Date signed (Mon	th, Day, Year)	
)	•		Mulan	Wor	Chi		De	185	d	Ju	1,2 E 18	,200	8
	8		30. Name and address of person who	GRE IM	death (Item 2	23a) (Type,	Print) De	beny!	lefthe	gti	sville !	4020	781
	Sta Regist		31. JUN 2 MOth 2008 (ar)	32. Registr	rar's Signatu	ire							

08-04932 Sepideh Ghazai	Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and	Mental Hygiene									
Physicial	1- For State Registrar Certificate of Death 1. Decedent's Name (First, Middle,Last)	Reg. No. 2008 2 6 2 1 6 2 2 1 2 2 Date of Death 3. Time of Death									
Medical Examin		June 26, 2008 Year 1221 hrs									
1	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo Shady Grove Hospital Rockville	ocation of Death 4c. County of Death Montgomery									
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or									
Director	0 8 2 7 0 8 2 3 9 1 M 2 x F 43 Yrs. Months Days Usual Residence of Decedent	Hours Min. 02/09/1965 Foreign Country) Iran									
) kue	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
Maryland 28a-f show	Maryland Montgomery North Po										
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shour other traumatic event, the Medical Examiner must be notified at once.	Maryland Montgomery North Po	10g. Citizen of What Country?									
h the		20878 U.S.A.									
death wit		anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.									
er dez		specify: Specify: Asian									
hours afte 'natural'' Examine	or Darles:	on (Give kind of work done 16b. Kind of Business/Industry									
n "nai	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. I	OO NOT use retired)									
5-0036 lied within 72 Hygiene. 4 other than 'the Medical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 IT Special 17. Father's Name (First, Middle, Last)	cialist University									
ore, MD 21215-003 (se I and 2 should be filed within of Health and Mental Hygiene. If iten 27 is marked other the traumatic event, the Med		8.Mother's Name (First, Middle, Maiden Surname)									
121stental I	Mohammad Taghi	Farangis Moharmmi									
D 21 should and Me 7 is ma		and Number or Rural Route Number, City or Town, State, Zip Code)									
, MD and 2 sho ealth and em 27 is rraumati	Farhad Khajehnoori - Husband 13 Flints Grove 20a. Method of Disposition 20b. Place of Disposition (Name of cem-	Drive, North Potomac, Maryland 20878 etery, Date 20c. Location - City or Town, State									
Baltimore, bernit. Pages I ar Department of Her Important: If ite	1 X Burial 2 Cremation 3 Removal from State crematory or other place)										
Baltimo permit. Page Department Important: injury or ott	4 Donation 5 Other Specify: Parklawn Memorial Park										
Balti permit. Departm Importa	21. Signature of Fundral Service Lidensee 22. Name and Address of Hines-Rinaldi	i Funeral Home, Inc.									
⊸ Physician	23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, s	mpshire Avenue, Silver Spring, Maryland 20904 uch as cardiac or respiratory arrest, shock, or heart Approximate Interval									
/Medical vaminer	Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of):	Between Onset and Death									
Q T T	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of):										
execu an and	M UNPENDED 23a,27,28a-f, perME, g882, 8/14/08 TT 28c&d per ME g882 8/27/08 TT										
760 cate b physic	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery									
Division of Vital Records, P.O. Box 68760, Mospital or Attending Physician: The law requires that the death certificate be ex 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician telly filled in by the funeral director, page 2 should be detached for use as the burial	28c&d per ME g882 8/27/ IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown Part II. Other significant conditions 28c&d per ME g882 8/27/ 1 Live birth 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Ectopic pregnancy Month Day Year									
O. B nat the d		ven in Part I. 23e. Did tobacco use contribute to the cause of death?									
es the		1 Yes 2 V No 3 Probably 4 Unknown									
Records, P.O. The law requires that the ficate has been signed by the page 2 should be detach.		24a. Was an autopsy findings available prior to completion of cause of death?									
Rec The Tre page		1 ✓ Yes 2 No 1 ✓ Yes 2 No									
Vital Rechysician: The this certificate	25. Was case referred to medical 26.Place (of Death (Check only one) Other: Nursing Home 5 Residence 6 Other:									
Physical China and direction of the china and di	Yes 2 No Inpatient 2 V ER/Outpatient 3 DOA										
on of tending Pi eath. or: After the funera		28d. Describe how injury occurred from balcony subject jumped from window									
Division (rate of the distriction of the death.) al Director: △ Hed in by the fu	1 Natural 5 Pending Investigation 3 X Suicide 6 Could not be determined (Specify) Building	28f. Location (Street and Number or Rural Royte Number, City or Town, State) 9636 Guldesky Dr. Rockville, MD									
Division of No the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dat (Check only one) 2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, and manyer stated. 29b. Signature and title of certifier 29c. License	e and place, and due to the cause(s) and manner as stated.									
To with	29b. Signature and title of certifier 29c. License O.C.N										
	30. Name and address of person who completed cause of death (Item 23a) David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore	e, MD 21201									
Sta Registr	31. Date filed (Month Dex, Year) Registrar's Signature										
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DHMH 17 Rev 1/2001 OCME 2006

			For State	State o	of Marylan	d / Depa	artment of H	lealth and N	Mental Hy	giene 2	108	21629
	-	V	State Registrar 1. Decedent's Name (First, Middle,	l ast)		Cel	rtificate of	Death	2. Date of Dea	109.110.	00	3. Time of Death
- 20	ysicia	ın	GRACE			457	_		Month	Day 7	Year	255 PM
A CONTRACT OF THE PARTY OF THE	Medic camin		4a. Facility Name (If not institution, g			101		r Location of Death		4c. County	of Death	2001
(1)3. 			Hospice of the								ARund	
Fun Dire	eral ctor		5. Social Security Number 6 374–16–6783	i. Sex 1 ☐ M 2 ☐ F XX	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	/, Year)	Countr	
-		- h	Usual Residence of Decedent						Nov.4,	1920	Michi	
laryla:	ed at	.	10a. State 10b. County Maryland Anne	Arundel		y, Town or Lo					10	d. Inside City Limits TYYes 2 □ No
the N	notifi	rect	10e. Street and Number	AT under	A	nnapol:	10f. Zip Code			10g. Citizen of	What Count	
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er dea	er mu	Funeral Director	11. Marital Status	Armed F		.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Ra	ce - America ck, White, e	
36 Is effe	xamin	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, G Year or D	iveXX oates:		I ☐ Yes 2☐ No	Specify:		Specia	y: Whi	te
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ж.			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ily one cause on	each line.							Approximate Interval Between Onset and Death
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Exami	iner			b.	(or us a conseq	derice or).	-	CLICIT	ARY U	13473	2	
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the d	ached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐Unkr		leath 5L	Other (specify) _					
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Vital Rec sician: The law certificate has b	or, pa		25. Was case referred to medical					26. Place of Dea	1□ Yes	2 No	1 ☐ Yes 2	lospice
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	y the f	cati	2 Accident investigat 3 Suicide 6 Could not	t ho	e of injury - At ho	ome farm str		Yes 2□No	28f. Location (S	Street and Num	her or Bural	Route Number
Div	d in by	Certification:	4 Homicide determine	build	ling, etc. (Specif	(y)	eet, factory, office		City or Tov	vn, State)	ber of Hurar	riodic ridinoci,
DIV To the Hospital or A within 24 hours after To the Funeral Dire			(Check only 2 Medical Ex	caminer : On the b	basis of examina	wledge, deatl	n occurred at the till vestigation, in my o	me, date and place	, and due to the	cause(s) and m	nanner as sta	ited. the cause(s)
o the l	omplet	Medical	one) 29b. Signature and title of certifier	and mar	nner stated.		29c. Licens			29d. Date sign		
⊢≯ř	Õ		Memle	4	hler	MO	10	0 0 0 0 0	- 1			~ /
100	B	7	30. Name and address of person wh	no completed cau	ise of death (Item	n 23a) (Type,	Print)	1/	11	,	7	21/08
. 17	2		31. Date filed (Month, Day, Year)	44	VKPMI egistrar's Signa	<u>MU 82</u>	U Veter	ans/16/	tnay 141	4ASU	ue M	11108
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 21630 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year 4:40 PM JUNE Carol E. Giacomelli 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Sinai Hospital of Baltimore City Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 5, 1942 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F NewYork Director 101-34-3001 66 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show The Medical Examplest must be notified at 1 ☐ Yes 2 No Directo New York Genesee LeRoy 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 14482 U.S.A. 57 West Main Street Apt.36 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 □ No Specify þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lens Maker(Contacts) 8 Laborer Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f is marked o John Scott 2 IInknown or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau
once. 2334 Pennyroyal Terrace, Baltimore, Maryland Dean Giacomelli Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maplewood Cemetery 7-2-08 Pavillon, New York 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. A. michael 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6009Harford Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UROSEPSIS

Due to (or as a consequence of): 1 week disease or condition resulting in death) /Medical Examiner Iweek Urinay tra tract Insection Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has I director, page 2 s autopsy perform 1 ☐Yes 2 ☑No 2 No 25. Was case referred to medical Be 26. Place of Death (Check onli one, 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death

To the Funeral Director:
completely filled in by the

Siacomelli

Patient

State Registrar

Medical

JUL 0 3 2008 DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of pertific

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JUNG 25, 2008

		1_ For State	State of Marylar	nd / Depai	tment of Hea	alth and M	Mental Hyg	gien 2 0 0 8	3 21632
		Registrar		Cert	ificate of De	eath		Reg. No.	
Physic	ian	Decedent's Name (First, Middle, La	st)	11	/		2. Date of Dea Month	Day Ye	3. Time of Death
/Medi		DOVIS Lee	Lane	Ha	1744		6	10 20	
Exami	ner	4e. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Loc	cation of Death		4c. County of I	,
			ner		Trincess	Anne	1	Some	
Funeral		5. Sociat Security Number 6. S	ex 7. Age (In yrs.	Yrs.		Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Da)	y, Year)	Birthplece (State or Foreign Country)
Director		Usual Residence of Decedent	/ /4	113.			0-20	1734 /	Modline
land		10a. State 10b. County	10c. Ci	ty, Town or Loca	ation				10d. Inside City Limits
Mary	10	MD Some	rest C	via Dia	1				1 Yes 2 No
the 128e	rec	10e. Street and Number	301 0	10116	10f. Zip Code			10g. Citizen of Wha	at Country?
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be filed within 72 hours after death with the Maryland hal Hygiene. Id Hygiene. d other then "natural", or Items 23a or 28e-1 show event, the Medical Exerginer must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.s. 13. W	as Decedent of Hispa	nic Origin? (Sp	pecify Yes or No-	14. Race -	American Indian,
or he		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give	İ	Yes, specify Cuban, M ☐ Yes 2 No S	nexican, ruent Specify:	nican, etc.)		White, etc.
ours ours	1 by	3 Widowed 4 □ Divorced	Year or Dates:			pocity.		Specify:	Black
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dithin of the control	du	Etementary/Secondary (0-12)	Cottege (1-4or 5+)	life. De	O NOT use retired)	_		c (0
led v tygie her t		17. Father's Name (First, Middle, Last,		Cra		Mathar's Nam	o (Eirat Middle	Maiden Sumame)	Χ
yically 2.1.2 build be filed with Mental Hygiene. srked other ther stic event, the	Be	17. Fallier's Name (First, Middle, Last,	1		10.	The stand	ia (11131, MILLOID.	Walder Surrame,	
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Tand Tand Health Health Health Health		20a, Method of Disposition	20b. F	Place of Disposi	tion (Name of	e, Vine	Date /V	20c. Location - Oit	y or Town, State
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Deficiency (May ylating Z.I.Z.13-0030) permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28e-1 show my highry or other treumatic event, the Medical Exercine crimatics at all 2008.		21. Signature of Funerat Service Licer		22.	Name and Address of		C17 (2)	- TSahello	Shoot
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/Medical		disease or condition resulting in death)	a. Due to (or as a consec	uence of):					16HKS
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entific ding p	Me	tF FEMALE:	23c. tf yes, outcome of pregna	2001					
atten for us	lan	23b. Was decedent pregnant in the past 12 mooths?	1 Live birth 2 Feta	it death 3 □E	ctopic pregnancy			23d. Date of Month	,
tha g	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	19atii 5 🗆 '	Other (specify)				
w requires that the death certific to been signed by the attending I should be detached for use as		Part It, Other significant conditions of	ontributing to death but not res	sulting in the und	lerlying cause given in	n Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
uires n sign d be	d by						1 D Y	/es 2 □ No 3[Probably 4 Honknown
k req	Completed						24a. Was	an 24b. Wei	re autopsy findings available
he la e has ige 2	dmo							rmed? dea	re autopsy findings available or to completion of cause of th?
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sicie s certi	00	examiner?	Hospitat: 1 ☐ Inpatient 2 ☐	ER/Outpatient	0+		th (Check only o	dence 6 ☐Other	(Spacify)
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a func	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		2 🗆 No			
*Attending Physicien: The laver of the laver of death. **Fector: After this certificate has by the funeral director, page 2	Hick	3 Suicide 6 Could not b	289. Place of injury - At n	ome, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number	or Rural Route Number,
s afte	Certification:	/ /	building, etc. (Special	7/			Jay or 104	, 51419/	
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Ph (Check only 2 Medical Exer	ysicien: To the best of my knoniner: On the basis of examina	owledge, death	occurred at the time, o	date and place	and due to the	cause(s) and mann	er as stated.
the H in 24 the F	ledical	one)	and manner stated.	and and of mye					
with To 1	Σ	29b. Signature and title of certifier	mo	2	29c. License nu			29d. Date signed (A	
2001			-		000	6291	6 -	LINE	19,2008
2001		30 Name and address of person who	completed cause of death (tter	m 23a) (Type, P	rint)	sian s	G100 19	? Souisa	nor MA
					ale / lo /.				21804
St	ate 🕆	31. Date filed (MJT) Na 2Y 0r) 20	Registrar's Signa	1 Ann	Ma				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AND TIEMS per H 882 8 108 W State of Maryland, Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18 Day **Physician** JUNE 2008 HIRNEISEN 22:57 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CECIL UNION HOSPITAL ELKTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Mn. MAY 1, Birthplace (State or Foreign Country) **22141045209** 222 10 5209 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 XX 86 DELAWARE Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 ☐ No NORTH EAST MD CECIL Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 135 WEST BRANCH CIRCLE 21901 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes XXNo Specify: Specify: Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) QUALITY CONTROL WORKER TEXTILES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANK CARLINI FELICIA POLIZIANI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 135 W. BRANCH CIRCLE, NORTH EAST, MD 21901 JOHN HIRNEISEN Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition GRACELAWN MEMORIAL 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JUNE 23, NEW CASTLE, DE 4 ☐ Donation 5 ☐ Other (Specify) PARK 2008 22. Name and Address of Facility
MEALEY FUNERAL HOMES, PO BOX 2866
WILMINGTON, DE 19805-0866 21. Signature of Funeral Service Licensee M00784 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction **Physician** hour /Medical Due to (or as a consequence of) **Examiner** 1-2 days Hypoxia Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) in by the funeral director, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy perform 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manprér of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my or inion, death occurred at the time, date and glace, and due to the cause(s) and manner stated. Aswegan 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

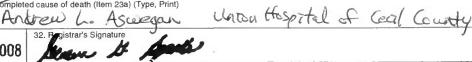
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Near) JUN 2 0 2008

29b. Signature and title of certifier

30. Name and address of person wh



impleted cause of death (Item 23a) (Type, Print)

00062687

6/14/08

State

ORIGINAL

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

and manner stated

32. Regit ar's S

, MSP

29b. Signature and title of certifier

Ling Li, MD

31. Date file 2/M Oth 2000 Bear,

hul

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Registra

29d. Date signed (Month, Day, Year)

June 16, 2008

2. Date of Death

		Please T
		_ For
		1 - State Registrar
Physicia		1. Decedent's Name (First, Middle, Last)
Physicia /Medic		Bessie Edna HENSO
Examin		4a. Facility Name (If not institution, give s
	М	Washington County
Funeral		5. Social Security Number 6. Sex
Director		Usual Residence of Decedent
rland ow at		10a. State 10b. County
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportanent: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	Maryland Washing
h the rr 28a	irec	10e. Street and Number
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15-(1721)	ete	15. Decedent's Educ (Specify only highest grade
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d 2 filed Hygier ther	Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)
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Shoul Me mark	ř	19a. Informant's Name/Relationship (Typ
Ma nd 2 s tith an		Patricia Rutherfor
re, s 1 au f Hea titem othe		20a. Method of Disposition
MO Page ento nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or any Injury or other traumatic event, the Medical Examisonce.		21. Signature of Funeral Service License
Bal permi Depa Impo any I	(7)	SCAUM
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or
Physician	(A)	Immediate Cause (Final disease or condition
/Medical		resulting in death)
Examiner		Sequentially list conditions,
72 ÷	iner	if any, leading to immediate
kecuted and I-transii	xamine	Cause (Disease or injury that initiated events resulting in death) Last
50, be ex	Ê	Todaming in dodain, 200
876 cate to ohysic	dica	
x 6 Sertific	/Me	IF FEMALE:
Bo eath atten for u	cian	in the past 12 months?
. the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
that the detail	/ Ph	Part II. Other significant conditions con
ds ruires ruid be	d b	out cell cancer a
w req	lete	gastron tishnal bl
Re he has	dmo	900010144011102 011
tal an: Tal ifficat	Ö	25. Was case referred to medical
Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be eafter death. The law requires that the death certificate has been signed by the attending physician but the funeral director, page 2 should be detached for use as the burial in by the funeral director, page 2.	O B	examiner?
g Ph g Ph er thi	n: T	27. Manner of Death
ath. ir: Aft	atio	1 Natural 5 Pending investigation
Vis r Atte er dea recto	tific	3 Suicide 6 Could not be 4 Homicide determined
Ital on rs aft refer in led in	Cer	
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical Certification: To Be Completed by Physician/Medical E	29a. Certifier 1. X Certifying Physical (Check only 2 Medical Exam)
the him 24 the F	ledi	one)
7 vitl	2	29b. Signature and title of certifier

ı	Bessie Edna HENSON					June	a	ž 20	8%	11:45 PM
ı	4a. Facility Name (If not institution, give street and number	r)		4b. City, Town, o	r Location of Death		4	c. County o	of Death	
	Washington County Hospita			Hagers				Wa	shin	
- Ł	4 D M 0127 E	Age (In yrs. 69	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Yea	r)	Coun	
-	214-36-2131 Usual Residence of Decedent					June 2	υ,	1939	Man	ryland
ŀ	10a. State 10b. County	10c. Cit	y, Town or L	.ocation					1	0d. Inside City Limits
5	Maryland Washington		Will	Liamsport						1 X Yes 2 □ No
3	10e. Street and Number	1		10f. Zip Code			10g. C	itizen of W	hat Coun	try?
1 1	105 South Vermont Street			217	95			USA		
	11. Marital Status 12. Was Decede Armed Force		.S. 13.	. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.))-		- Americ , White,	an Indian, etc.
	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 [If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date:			1 ☐ Yes 2 🖾 No	Specify:			Specify:	wh	ite
3	3 ☐ Widowed 4 ☐ Divorced Year or Date:	5.	16a Dec	edent's Usual Occup	nation		16b.	Kind of Bus	siness/Inc	dustry
	(Specify only highest grade completed)	- F.)	I (Giv	e kind of work done DO NOT use retire	during most of wor	king	Î			
	Elementary/Secondary (0-12) College (1-40)	or 5+)		homemake	r			her o	wn h	ome
	17. Father's Name (First, Middle, Last)		-		18. Mother's Nan	ne (First, Middle	, Maide	en Surname	e)	
	George Franklin Murray				Daisy N	lae Bett	s			
	19a. Informant's Name/Relationship (Type. Print)			ling Address (Street						
	Patricia Rutherford - dau				ury St.,	Apt. B,		11iam		t,Md.21795
1	20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	te (cemetery, cr	oosition (Name of ematory or other pla					•	· =
	4 ☐ Donation 5 ☐ Other (Specify)	Sh		wn Cemeter				- 6		Maryland
1	21. Signature of Funeral Service Licensee			22. Name and Addre	1.1	INNICH				01740
+	23a Part 1 Enter the disease or complications that cause	sed the deal	b Do not e	415 E. Wi	no such as cardiad	or respiratory	rst.	own,	Md.	21740 Approximate
	23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each immediate Cause (Final	.00	ii. Bo not o	ino. tilo iliodo or ay.			,			Interval Between Onset and Death
	disease or condition	as a consec	wonco of):				_		-	10 days
	Sequentially list conditions h		derice or).							10 days
5		as a consec	uence of):							
	if any, leading to immediate cause. Ener Uncorpying Cause (Disease or injury that initiated events									
ì		as a consec	uence of):							
3	d									
	IF FEMALE:	ma of progo	2004		-			401.0		
	23b. Was decedent pregnant in the past 12 months?	n 2 ☐ Feta	al death 3	Ectopic pregnanc	;y			23d. Date Mor	e of delive nth	ery Day Year
	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Jean S	□ Outer (specify) _						
	Part II. Other significant conditions contributing to deat	h but not res	ulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacc	o use contr	ribute to t	he cause of death?
2	Out cell cancer, aute re	rol fa	.hurz	atrial fi	brillation	, 🔀	Yes	2□No	3 ☐ Prob	oably 4 □Unknown
	gastroin tishnal black De	incy to	Denica		•	24a. Wa		24b. V	Nere auto	ppsy findings available
3	1		<i>p</i>			per	opsy formed	? 'c	onor to co death? i ∐Yes	mpletion of cause of 2 No
۱ (25. Was case referred to medical				26. Place of Dea					
2	examiner?	atient 2□] ER/Outpati	ent 3□ DOA Ot	her: 4 ☐ Nursing F	lome 5 ☐ Res	sidence	6 □Oth	er (Specia	fy)
5	27. Manner of Death 1. Annual 5 □ Pending 28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time Injury	/ Wo		28d. Describe	how in	ijury occurr	eď	
Oct till cation:	2 Accident investigation	fortune. AA le	(]Yes 2□No	OOA Lagation	/Ctun n f	and Numb	or or Pur	al Route Number,
	determined 200. Flace of	, etc. (Speci	fy)	street, factory, office		City or To			er or num	ai moute ivamber,
	29a. Certifier 1/X Certifying Physician: To the bo	est of my kn	owiedge, de	ath occurred at the t	time, date and place	e, and due to th	e cause	e(s) and ma	anner as s	stated.
Calca	(Check only 2 Medical Examiner: On the bas	is of examin								
S I	29b. Signature and title of certifier			29c. License number 29d. Date sig				Date signed	d (Month,	Day, Year)
	Ma Mo			158	195		01	/23	1200	8
	30. Name and address of person who completed cause			e, Print)	2140			`		
		69251		40 21	170					
	31. Date filed (Month, Pay, Year) 2008 32. R	Palania	J.	book						

State Registrar

CSH3

Certificate of Death

12

State Registrar (Check only one)

29b. Signature and title of tifier

Barry N. 31. Date filed (Month, Pay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rosenbaum MD

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D09834

3720 Farragut Avenue Kennsington MD 20895

29d. Date signed (Month, Day, Year)

6/18/08

State of Maryland / Department of Health and Mental Hygiene 0 08 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5:00 AM 2008 JUNIE MAŁ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Somerset PINE KNOLL drive Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Months 213-14-7186 Yrs. MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c, City, Town or Location 10a. State 10b. County or Items 23a or 28a-f show the Medical Examiner rount by notified at Md 1 Yes 2 No Princess Somerset Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2185 5-4 307 KNUI drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11, Marital Status Black White etc. 1 Never Married 2 Married BIACK 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HouseKeeping Elementary/Secondary (0-12) College (1-4or 5+) WOLKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hient; If item 27 is marked other. ANNA Samuel other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pine Department of Health a Importent: If item 27 is any injury or other trainone. 30492 KNOIL dr. PriNCPSS anne, Shirley M. -daughter 20c. Location - City or Town, State West Post office 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State MARYS B.C. Com. 6-15-08 Princess anne, ma * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Home 177 W. Isabella St. Jalisbi 21. Signature of Funeral Service Licenses Salisbury, md 2185 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) CHRONIC KIANEY **Physician** /Medical Examiner MELLITUS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed tor use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months?

1 Yes 2 10

9 Unknown 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ N 12-N510~ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ Mo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 🔲 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00062418 JUNE 17,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH DIESSON SHITE & SALBBURT MO 6 unihor 1416 31. Date filed (Month, Day, Year) 32 Registrar's Signature JUN 1 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2008 **Physician** 9:40F M Aida Habeeballah /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Towson Baltimore Center 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 💥 □ F Director April8.1924 Georgia 146-12-2546 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exordination to other traumatic event, the Medical Exordination of the modified at Yes 2 No Director NewJersey Camden Camden 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 08103 626 Kaighns Avenue Funeral U.S. Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 【YNo Specify Specify: Black 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Production Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Brown Rowena 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 21236 19a. Informant's Name/Relationship (Type. Print) Margo Judge Watts 4313Bedrock Circle#201, Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Oak Grove Cemetery 6-28-08 Hammonton, New Jersey 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009Harford Road, Baltimore, Maryland21214 1. Marzullo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE CHRONIC OBSTRUCTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PULMONARY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) P.O. the 9 I Unknown ģ signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy the Hospital or Attending Physician: The ormed? 2 ZNo certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Appatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation thin 24 hours after death.

the Funeral Director: After the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 29c. License numbe 0 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 TM M. D. 7601 THE 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** A^{M} 26 2008 0830 June Ralph Vernon Hart /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 E1kton 112 Brown Street if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1 MM 2 □ F May 27, 1929 216-24-9012 79 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show 1 X Yes 2 □ No notifled Director Maryland Ceci1 E1kton permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items on any Injury or other trailment. 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code United States 21921 112 Brown Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Q 5 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 MYes 2 No 1951-If Yes, Give Year or Dates: 1953 Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21☑ No Specify. þ 3 ₩ Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educational College (1-4or 5+) Elementary/Secondary (0-12) Institution Maintenance Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine May Gallaway Frank Leon Hart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24014 1920 Redwood Rd. SE, Roanoke, VAJeanette M. Jeter/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) June 30. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bethel Cemetery 2008 4 □ Donation 5 □ Other (Specify) Chesapeake City, MD 22. Name and Address of Facility
Hicks Home for Funerals,
103 W. Stockton Street 21. Signature of Funeral Service Licensee Stockton Street, Elkton 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part i. ð 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 1□ Yes 2 Vio 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

The law requires that the death certificate be executed Hospital or Attending Physician: After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

s been signed by the s certificate has bractor, page 2 s

the 9+1

State Registrar

4 Homicide

29a. Certifier (Check only one)

and manner stated 29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day,

State of Marvland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008^{ar} 25 1846 June **Physician** Barbara A. Harris /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 E1kton Union Hospital 9. Birthplace (State or Foreign Country)
New Jersey If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, NOV 2, 193 7. Age (In yrs. last birthday) 5 Social Security Number Months **Funeral** 1 M 2 1 F 147-28-5687 Director Usual Residence of Decedent 10d Inside City Limits регтііt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medi al Examiner must be notified at 10c. City, Town or Location 10a. State 10b County 1 ☐ Yes 2 X No Director E1kton Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 35 Perch Creek Road Funeral 14. Race - Americen Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: Baltimore, Maryland 21215-0036 White þ 3 ☐ Widowed 4 ☐ Divorced 16h Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Card Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Sutton George Pfleghar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 35 Perch Creek Road, Elkton, MD 21921 John J. Harris/Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 30, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Bank Cemetery 2008 Calvert, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death lδ Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s has this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 1 Inpatient 2□ No 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of To the Funeral Director: After the completely filled in by the funeral 27. Manger of Death 28c. Injury at Work? Certification: Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of certifier D0062687 08 use of death (Item 23a) (Type, Print) who completed 30. Name and address of person Union Happital of Ceal Cours 32. Registrar's Signature Ardrew 31. Date filed (Month, Day, Year) State Registrar

			1 - State of Registrar	Maryland / Depa <i>Ce</i>	artment of He <i>rtificate of D</i>		I Hygiene Reg. No 2	800	21641
	Physici		1. Decedent's Name (First, Middle, Last) Leroy Dougle	as	Hiles	Mor	of Death oth Day	Year 2008	3. Time of Death
- Search	/Medic Examin		4a. Facility Name (If not institution, give street and numb Washington County Hospita		4b. City, Town, or L		4c. Co	unty of Death	rgion
*	Funeral Director		5. Social Security Number 6. Sex 7 236 60 2973	Age (In yrs. last birthday) 69 Yrs.	1000		e of Birth		ace (State or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State	10c. City, Town or Lo Berkele	ocation by Springs			10	d. Inside City Limits 1 □Yes ※XXNo
	h with the	Funeral Director	10e. Street and Number 55 Highland Ridge Road		10f. Zip Code 25411			of What Countr	y?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evair ding 1, ust be notified at once.	by Funer	11. Marital Status 1 Never Married Married Armed Force Armed Forc	□No		panic Origin? (Specify Yes Mexican, Puerto Rican, e Specify:		Race - America Black, White, et ecify: Whi	c.
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	filed witl Hygiene other tha	e Corr	12 17. Father's Name (First, Middle, Last)	Rural	mail carr	8. Mother's Name (First,			Service
ylan	ould be I Mental narked c	To Be	Harry Marsh		Hiles	Ethel	Lee		Crouse
, Mar	and 2 sh salth and 1.27 Is m er traum		19a. Informant's Name/Relationship (Type. Print) Mary C. Hiles - Wife			d Number or Rural Route dge Road, Be			
Baltimore, Maryland	. Pages 1 a tment of He tant: If item jury or othe		20a. Method of Disposition XX Burlal 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)	Mt. Plea	ematory or other place) Isant Cemet	ery 6/28/08	Berke		ings, WV
Ball	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	м00522	2. Name and Address IEISIEY—Joh 15. Union St	nson Funera Berkeley	l Home, I	nc. WV 254	11_1855
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caus hock, or heart failure. List only one cause on each lmmediate Cause (Final disease or condition resulting in death) a. Due to (or part of the disease)	ised the death. Do not en	nter the mode of dying,	guch as cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying	r as a consequence of):					
68760, 🜣	ificate be executed g physician and as the burial-transit	edical Examiner	that initiated events	as a consequence of):	(GR (-3(C	le pleva	X em	sia	
O. Box	ath cert	Physician/Med	in the past 12 months?	nt at time of death 5[☐ Ectopic pregnancy ☐ Other (specify)		230	d. Date of deliver	ry Day Year
rds, P.	tuires that the de n signed by the a ld be detached f	by	Part II. Other significant conditions contributing to dea	_	underlying cause giver	in Part I. 23	e. Did tobacco use 1 □ Yes 2 🗹		e cause of death?
Vital Record	: The law require cate has been si page 2 should b	Completed	Non-insulin depe	enclos no	ર જકાઇ		a. Was an autopsy performed?	24b. Were autop prior to con death? 1 □ Yes	sy findings available apletion of cause of
	ysician is certifi director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	patient 2 ER/Outpatie	Othor	26. Place of Death (Chec		Other (Specify	•)
on of	ding Physician: The In. After this certificate hifuneral director, page	ion: T	27. Mann Leath 28a. Date of (Month)		of 28c. Injury Work?		escribe how injury o	- 1, , ,	/
Division of	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Certification: To		f Injury - At home, farm, st g, etc. <i>(Specify)</i>		28f. Loc	cation (Street and N y or Town, State)	Number or Rural	Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edical C	29a. Certifier 1 Certifying Physician: To the base one) 2 Medical Examiner: On the base and manner	is of examination and/or in					
	To the within 2 To the comple	M	29b. Signature and title of certifier	a7/4.5 1.	29c. License	number	29d. Date s	signed (Month, L	Day, Year)
	1541		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print) 25	(E. A.	tieten	557	1993
	Sta Registr			gistrar's Signature	و فران	ges jeur	V /VI	01/	70
	negisti	41	JOE O G TOOL TOOL	w so page	OG.				

State of Maryland / Department of Health and Mental Hygiene 2000

		For State Registrar		Cei	tificate of L	Death	Reg	No. 200	8 21642	
Physic /Medi		Decedent's Name (First, Middle Nancy		Haywar	d		2. Date of Death Month Jun 25,	2008 Year	3. Time of Death 1:10pm M	
Exami		4a. Facility Name (If not institution Golden Living	, give street and number)		4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany		
Funeral Director	2	5. Social Security Number 571-38-3586	6. Sex 1 M 2 X F 7. Age (In yrs. 93	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sep 16,	9. B	irthplace (State or Foreign Country)	
e Maryland 3a-f show tiffied at	Director	Usual Residence of Decedent 10a. State MD Alle	egany 10c. Ci	ity, Town or Lo Cum	nberland				10d. Inside City Limits	
th with the 23a or 28 ust be no		10e. Street and Number 801 Memorial Avenue			10f. Zip Code	21502		10g. Citizen of What Country? USA		
aryland 21215-60036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. a marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	r Married 2 ☐ Married I ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)		Was Decedent of His fYes, specify Cubar I□Yes 2□ X io	spanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	(Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc. Specify: white		
7275-U	Completed	(Specify only higher Elementary/Secondary (0-12)			lent's Usual Occupa kind of work done d DO NOT use retired; SECRETATY	ation luring most of worki	ng	b. Kind of Busines	·	
Maryland 2121 td 2 should be filed within th and Mental Hygiene. 77 Is marked other than " traumatic event, the Med	To Be Co	17. Father's Name (First, Middle,	_{Last)} eland VanMeter	legal		18. Mother's Name	(First, Middle, Ma		10111000	
Mith a lith a 27 is r train	ľ	19a. Informant's Name/Relations Tracey Goldsv			ng Address (Street a		al Route Number, C Cumb		, Zip Code) MD 21502	
altimore, mit. Pages 1 ar partment of Hea portant; if Item y Injury or other		20a. Method of Disposition 1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from State Qu	cemetery, crer leens Poi	sition (Name of natory or other place nt Cemetery	9)	6/28/2008	Keyser	or Town, State	
Baltime permit. Pag Department Important: I any injury o		21. Signature of Pureral Service Library e 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502								
Physician /Medical		23a Part1. Enter the disease, or condications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immedia! Cause (Final disease or condition resulting in death) Due to the second accordance of the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Second Conset and Death Secon								
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rtificate be executed og physician and as the burial-transit	Medical Exa	resulting in death) Last	Due to (or as a consec	C. Due to (or as a consequence of):						
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UNVISION OF VITA I or Attending Physician: after death. Director: After this certification by the funeral director.		The restaurce of the re							Journey	
	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Lothe Hospital within 24 hours a Tothe Funeral I completely filled	Medical	(Check only 2 Medical one)	g Physician: To the best of my kn Examiner: On the basis of examin and manner stated.		vestigation, in my o	pinion, death occur	red at the time, dat	e and place, and o	lue to the cause(s)	
To with To com	Σ	29b. Signature and title of certifie	wo flan	m	29c. License	5400°	290	1. Date signed (Mo	nth, Day, Year)	
le		30. Name, and address of person	who comple ed cause of death (Ite	m 23a) (Type,	Print) Mati	onal to	lighwar	LaVal	e M/21500	
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	rature	V		5)	1.10	

			1 - For State Registrar	State of Ma		rtificate of			leg. No.	21040	
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea Month	ith Day Year	3. Time of Death	
	Physici /Medic		George T	. Jo	nes			June	17, 2008	18:06 M	
	Examin		4a. Facility Name (If not institution, giv	e street and number)	itreet and number)		4b. City, Town, or Location of Death		4c. County of Deat	n	
			320 W. Main Str			Elkton			Ceci1 h 9. Birthplace (State or Foreign		
	Funeral Director		221-30-4866	Sex 7. Age	e (In yrs. last birthday 60 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov.18,	Year) Co 1947 Wi	lmington, DE	
Maryland 2	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	a-f ehc	ctor	MD Cecil Elkton					1 ☐ Yes 2 ☑ No			
	or 28	Dire	10e. Street and Number 10f. Zip Code					10g. Citizen of What Country?			
	• 23a	rai	320 W. Main Stre	et 12. Was Decedent I	Ever in II C 12	2192		acify Ves or No-	USA 14. Race - Ame	nican Indian.	
	permit. Peges 1 end 2 should be filled within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at angles.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 ADivorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		If Yes, specify Cubi	dispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, White		
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	Hygien Hygien Sther ti	ŝ	17. Father's Name (First, Middle, Last	disabled disabled		18. Mother's Name	Mother's Name (First, Middle, Maiden Surname)				
	d be f ental l	To Be	John R. Jones, J					ret E. (
	12 should be a nand Mental if is marked or raumatic even		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street	and Number or Rura	al Route Numbe	r, City or Town, State, 2	Zip Code)	
	end 2:		Richard G. Jones	(brother)	65	Two River	rs Lane (Chesapea	ake City, M	D 21915	
	of Heering		20a. Method of Disposition	Demount from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City or	Town, State	
E	Peges nent of ant: If it ary or o		1 Burial 2 Formation 3 Removal from State 4 Donation 5 Other (Specify) Silverbrook Crematory June 19,2008 Wilm., DE								
Baltimore,	permit. Peges 1 end. Department of Heelth Important: if Item 27 eny Injury or other tr QDGs.		21. Signature of Funeral Service Licensee McCrery Funeral Homes, Inc. 3924 Concord Pike Wilmington, DE 19803								
7			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):								
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Box	The law requires that the deeth certificate be executed ate has been signed by the ettending physicien end page 2 should be deteched for use as the buriel-trensit	Completed by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		у		23d. Date of delivery Month Day Year			
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Ö	w requir been si should	ete	Dialostos	holl tus	- 7/			24a, Was	an 24b. Were at	utopsy findings available	
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Vital		0	25. Was case referred to medical	<u> </u>			26. Place of Deat			2010	
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_	ding Phy th. After thi funeral o		27. Manner of ath 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Work?							
	Attending r death. sctor: After by the fune	atlc	2 ☐ Accident investigatio	on M 1 Yes 2 No							
)įVį	To the Hospitel or Attendii within 24 hours effer death. To the Funerel Director; A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
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	24 hc 24 hc Fun letely	edical	(Check only 2 Medical Example)	miner: On the basis of and manner sta	f examination and/or i	nvestigation, in my	opinion, death occur	red at the time,	date and place, and due to the cause(s)		
	within To th compl	Me	29b. Signature and title of certifier	. //	1	29c. Licens	se number		29d. Date signed (Moni		
			Barbara	a 1/2	1 ON M	1 12	5915		618	08	
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)											
			Barbara A. Pa	rey, MD 1	11 W. High	St. Su	ite 214	Elkton,	MD		
	Sta Registi		31. Date filed (Month, Day, Year) 20 2()08 Registr	rar's Signature	ode					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 16, 2008 **JACKSON** JUNE 1938 JESSIE MAE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S MARYLAND HOSPITAL CENTER CLINTON SOUTHERN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day) 6. Sex **Funeral** Months 1 ☐ M 2 🖾 F 72 7/27/1935 Director 245-64-6438 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Examiner must be notified at Yes 2 □ No Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3420 Rickey Ave. 20748 United States Funeral death 1 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify:Black Completed by 3 Widowed 4 Divorced "natural" it of Health and Mental Hygiene.

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1 ☐ Yes 2【 No 24a. Was an certificate has b irector, page 2 s autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled i 29a. Certifier 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical mpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ca MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Livingston Rd 11701 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 01/1 0095 2008 /Medical 4a. Facility Name (If not institution, give street and number) 1378 Almond Drive 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/04/1950 5. Social Security Number 7. Age (In yrs. last birthday) 57 Yrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F North Carolina 577 68 8778 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County MD Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1378 Almond Drive 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Salesman Financial Services 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Kenneth Jones Norma Jane Seneff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beth Cranmer (sister) 5011 Indian Lane/College Park MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/16/08 Alexandria VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Services Wolled Annapolis MD and Falls Church VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NJOER V-2 a1 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | ✓ Onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rmed? 2 ✓ No or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: # 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier (Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

JUN 1 7 2008

- Suite 300 Amplis MO 21411

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

900

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** $10:45A^{M}$ 23, Yolanda <u>Jackson</u> June 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year)

March 26,1965 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F 43 March Wash., DC Director 577-86-4003 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The state of Health and Mental Hygiene and It file to 72 is marked other than "natural", or items 23a or 28a-f show that It file the training the notified at ury or other traumatic event. It will die I minner must be notified at 10d. Inside City Limits 10c. City, Town or Location t0a State 10b. County 1 XYes 2 No Director Silver Spring Md. Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 United States 8502 16th St. #318 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>dministrative Assistant</u> Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Valeria</u> ပ Donald Jackson Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8502 16th Street #318
Silver Spring, Md. 20910

20b. Place of Disposition (Name of cemetery, crematory or other place) Valeria Jackson/mother 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important; If any Injury or once. Washington Nat. Cem. 7/2/08 | Suitland, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 23a. Parti. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. 3910 Silver Hill Rd., Suitland, Md. 20746 Immediate Cause (Final **Physician** Metastatic Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner as the burial-tran Due to (or as a consequence of): 68760 attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) a∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death? Pleural effusions 24a. Was an page 2 autopsy 2 No 1 □Yes 2 No Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner 1 ∏ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DCA Medical Certification: To this Division of 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred lospital or Attending P I hours after death. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier соmpletely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5. wilks D0063195 June 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Wilks, 8600 Old Georgetown Rd., Bethesda, Md. 20814 Steven 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 03 Registrar

DHMH 17 Rev 1/2001

DIANDA

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25. Was case referred to medical examiner? Second Pack Pac	.O. Box 6	the death certific y the attending p ched for use as	ıysician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live bir 4 ☐ Pregna	death 3		у		1					
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29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sima Nourani Zenus, M.D., 8600 01d Georgetown Rd., Bethesda, MD 20814	l Reco		omplete							autor	psy ormed?	prior to co death?	empletion of cause of		
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29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sima Nourani Zenus, M.D., 8600 01d Georgetown Rd., Bethesda, MD 20814	o	ath. rr: Afte	atior	2 ☐ Accident investigation	Found 06/18/	Day, Year)		P M Worl		I					
29a. Certifier (Check only 2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sima Nourani Zenus, M.D., 8600 Old Georgetown Rd., Bethesda, MD 20814	DIVIS	al or Atte	Sertific		28e. Place of	Injury - At ho	me, farm, sti reet	reet, factory, office		City or To	wn_StateL				
June 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sima Nourani Zenus, M.D., 8600 Old Georgetown Rd., Bethesda, MD 20814		he Hospit in 24 hour he Funers pletely fills		(Check only 2 Medical Examin	on the bas	is of examina	wledge, deat	h occurred at the tinvestigation, in my o	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) and date and place	manner as e, and due t	stated. to the cause(s)		
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Sima Nourani Zenus, M.D., 8600 Old Georgetown Rd., Bethesda, MD 20814	1	THE		Mad dila	moleta	Secure (112	020\ /T	D006	5100		Julie 2.	-, 200			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:50PM Ethel Langhorn June 2008 16, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LaPlata harle. Medical Vista If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F 230 28 0359 12/15/1923 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at XXYes 2 □ No Director MDWaldorf Charles County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8336 Venture Drive 23603 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No **Black** Specify: ≥ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Leggtts Department Elementary/Secondary (0-12) College (1-4or 5+) Sales women Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude English Marvin Rice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8336 Venture Dr. Waldorf, Maryland 23603 Richie L. Queen DAUGHTER Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition rt. Hill Memorial Park 1X Burial 2 ☐ Cremation 3 ☐Removal from State 06/21/2008 Lynchburg, Virginia 4 Donation 5 Dother (Specify) 22. Name and Address of Facility ohn T. Rhines Funeral Home, LLC 21. Signature of Funeral Se Licens 3005 12th Street NE W.Washington, DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ancroed Sequentially flet our diffuse, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and burial-trar Due to (gras a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 🛣 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Cartias 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

hours after death uneral Director: hin 24 hours a within To the

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State Registrar 29b. Signature and title of certifier

and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Washington Rd, Ste. 203A

29d. Date signed (Month, Day, Year)

Waldorf

			1 - State State Registrar	of Maryland /		rtment of tificate of		nd Me	ntal Hy	giene Reg. No. 2 (008	21649
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H	Funeral Director	Г	5. Social Security Number 6. Sex 577-20- 4652 1 ☐ M 2	7. Age (In vrs. last b	rthday) Yrs.	If Under 1 Year Months Days		Min	Date of Birt (Month, Da	h , Year) 1921	Count	ace (State or Foreign ry) .ngton, DC
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9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical English and It. Medical English and Denge.	by Funeral	Armed F 1 □ Never Married 2 Married 1 □ Yes			Vas Decedent of Yes, specify Cu □Yes 2 No		n? (Specii Puerto Ric	fy Yes or No- can, etc.)		ace - America lack, White, e city:White	ic.
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lary	2 shot and h is ma		19a. Informant's Name/Relationship (Type. Print)			g Address (Stree				-		Code)
e, ≅	1 and Health Health Her tr		Jean Riedl/Daughter 20a. Method of Disposition			Lebeck C	ourt,]	India Date			46226 n - City or Tov	un State
imore,	Pages ment of I ant: If its ury or of	-	NETION OF DISPOSITION NETION OF DISPOSITION 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	cemet	ery, crem	atory or other pl		, Jun	e 18		•	ng,_Marylan
Baiti	permit Depart Import any inj		21. Signature of Funeral Service Licensee	6	22. F1 50	Name and Add Cancis J O Unive	ess of Facility Collinersity	ins F Blvd,	unera W,.	l Home Silver	Inc. Spring	, MD 20901
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do	not ente	r the mode of d	ring, such as ca	ardiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death
1	hysician /Medical		resulting in death)	e Myocard		Infarcti	.on					Onset and Death
1	Examiner		Due to	(or as a consequence diogenic Sh	,							
		je.	Sequentially list conditions	(or as a consequence								
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		- 0							
8/00,	icate be executed physician and the burial-transit	al E	Due to	(or as a consequence	or):							
20	mcate g phys	edical	d									
O. BOX	To the hospital of Attending Physician : The law fequires that the death certification within 24 bours after deathing. To the Fuhoriar Birector: After this certificate has been signed by the aftending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									ry Day Year
ζ.	ed by detact		9 ☐ Unknown Part II. Other significant conditions contributing to a	death but not resulting	in the un	derlying cause g	iven in Part I.		23e. Did to	bacco use co	ontribute to the	e cause of death?
ecords,	equires een sign ould be	ted by						_ //	1 🗆 Y	′es 2. y No	3 ☐ Proba	ably 4 ☐ Unknown
, ec	ine law r ate has be	Completed						_			b. Were autop prior to con death? 1 ☐ Yes	sy findings available apletion of cause of
ן אונשו	cran: ertifica ector, p	Be C	25. Was case referred to medical examiner?					of Death (0	Check only o			
5 1	ang Pnysician: The Tr. After this certificate h funeral director, page	ျဉ			utpatient Time of	3 □ DOA O 28c. Inj				lence 6 C)
S S	th. : After	tion		nth, Day, Year)	Injury	We	ork? ∐Yes 2∐No		i. Describe i	low injury occ	urrea	
	after dea Director d in by the	Certification:	a Cloudettle 6 Cloude not be	e of Injury - At home, f ling, etc. <i>(Specify)</i>	arm, stre	et, factory, office		281	Location (S City or Tox		mber or Rural	Route Number,
:	lo the hospital of Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 CCertifying Physician: To the 2 Medical Examiner: On the and ma	e best of my knowledge basis of examination a	je, death nd/or inv	occurred at the estigation, in my	time, date and opinion, death	place, an occurred	d due to the at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
:	vithin To the compl	Me	29b. Signature and title of certifier			29c. Licer	se number			29d. Date sign	ned (Month, E	Pay, Year)
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ì	Sta Registr		31. Date filed (Month Par Year 9 2008 32.	Registrar's Signature	1 16	and .						

			For State	State	of Maryla	and / Depa <i>Cer</i>	irtment	of He	ealth and N Death	/lental Hyo	giene ,	2008	21650	
ŗ.	· · · · · · · · · · · · · · · · · · ·		Registrar 1. Decedent's Name (First, Middle					-		2. Date of Dea	ıth		3. Time of Death	
	Physicia /Medic		Mary Anna Le	edson						June 1	5, [□] 20	08 Year	10:00 AMM	
)	Examin	- 1	4a. Facility Name (If not institution	_	umber)				Location of Death		4c. C	1 1		
of a market			3601 Aspen (1 7 A (In.	14 bi-4-4-1	Davi		ville If Under 24 Hrs.	8. Date of Birt	<u> </u>	nne Aru	ngel	
	Funeral Director		5. Social Security Number 215-44-4853	6. Sex 1 ☐ M 2 🔭 F	62	vrs. last birthday) Yrs.	Months	Days	Hours Min.	Nov. 8	, Year) 194	5 Wash	ington,DC	
	pu ,		Usual Residence of Decedent		100	City, Town or Lo	cation					11	0d. Inside City Limits	
	show show	5	10a. State 10b. County		100.	•						'	1 □ Yes 2 ☑ No	
	the M	ecto	Maryland Anne A	Arundel		Davidso	10f. Zip				10g. Citize	en of What Cour	ntry?	
	3a or	<u>ā</u>	3601 Aspen Cour	rt				2103	5			USA		
	death	Funeral Director	11. Marital Status	12. Was De	ecedent Ever in Forces?	n U.S. 13.1	Vas Deced	lent of His	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	. 14	1. Race - Americ Black, White,		
30	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if Health and Mental Hygiene. If filem 27 is marked other than "natural", or items 23a or 28a-f show if if them 27 is marked other than "natural", or items 2 be notified at or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married XX 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Ye	s 2 No Give X		1 ☐ Yes 2	17	Specify:		5	Specify: Whi	te	
0500-CI	2 hour	led b	15. Deceden	nt's Education		16a. Dece	dent's Usua	l Occupa	tion		16b. Kind	d of Business/In	dustry	
<u>د</u>	thin 7% e. an "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)		1) (1-4or 5+)				uring most of work			o .		
7	ed wil ygien ner th	S		2		Direc	tor c		man Resc			ın Servi	ces	
and	12 should be filed within 'h and Mental Hygiene. 7 Is marked other than "r traumatic event, the Med	Be	17. Father's Name (First, Middle, James Merle Ma							n McMain		umame)		
Ž	should nd Me mark matic	၉	19a Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	and 2 :		Francis J. Ledson/Husband 3601 Aspen Court, Davidsonville, Md. 21035											
ore,	permit. Pages 1 an Department of Heal Important; If item 2 any Injury or other once.		20a. Method of Disposition 1, Buriat 2 □ Cremation	3 □Removal fro	m State	b. Place of Dispo cemetery, crea	sition (Nan matory or o	ne of ther place	a)	Date	20c. Loca	ation - City or To	own, State	
altimor	t. Pag tment tant;		4 Deponation 5 □ Other (Specify) Lakemont Mem. Gardens: 6-23-08 Davidsonville, Md. 21035 21. Signature of Specifice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home											
ga	permir Depar Impor any Ir once,		21. Signatus of Service	Licensee					GE				Md.21037	
£	- * *		23a. Part1. Enter the disease, o	r complications tha	it caused the d							water	Approximate Interval Between	
	Physician	6	shock, or heart failure. List immediate Cause (Final disease or condition	t only one cause of	-	dometiv	Ial	600	cinomò	,			Onset and Death	
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	Examiner	_	Sequentially list conditions,	b. — Due	to (or as a con	sequence of):								
	uted I Insit	Examine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\$	(0) 45 4 55									
oʻ	an and rial-tra	Еха	resulting in death) Last	Due	to (or as a con	sequence of):				1010.				
8/60	The law requires that the death certificate be executed tte has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	dical		d										
٥	leath certific attending p	a a	IF FEMALE:	23c. If yes.	outcome pf pre	egnancy					2	3d. Date of deliv	reny	
X R R O	death atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Liv 4□Pre	e birth 2 🔲 I egnant at time	Fetal death 3	⊒Ectopic pr ⊒Other <i>(</i> sp					Month	Day Year	
r Ö	t the c by the	hysi	9 □ Unknown	9∐Un										
	w requires that the debeen signed by the should be detached	þ	Part II. Other significant condition	1 d	X		nderlying c	ause give	en in Part I.	23e. Did t	1		the cause of death? bably 4 Unknown	
0.0	requii	eted	Coronar			ceecc				24a. Was			opsy findings available	
Vital Records,	sician: The law certificate has birector, page 2 s	Completed	Diabeta	& Melli-	I US					auto perfo	osy ormed?	prior to co death?	ompletion of cause of	
tal		ပ္ပိ	25. Was case referred to medica	al					26. Place of Dea	1 Yes ath <i>Check onl</i> o	20XNo	1 □ Yes	2□No	
	ysician: iis certific director,	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	☐ Inpatient	2 ER/Outpatie	nt 3□ DC	Othe	ar.	lame 5 XResi		☐Other (Spec	ify)	
n or	ttending Phys Jeath. :tor: After this (on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi		ite of Injury Ionth, Day Yea	28b. Time of Injury		28c. Injury Work		28d. Describe	how injury	occurred		
<u> </u>	ttendi death. stor: A	cati	2 Accident invest	not be	ace of injury -	At home, farm, st	M reet factor		Yes 2 □ No	28f Location (Street and	f Number or Rui	ral Route Number,	
Division	after of Direct of Direct of the by	Certification:	4 ☐ Homicide determ	nined 206. Fi	ilding, etc. (Sp	pecify)		,, 0.11.00		City or To				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifyi 2 Medica	ng Physician: To I Examiner: On th and m	the best of my e basis of exam anner stated.	knowledge, dea mination and/or in	th occurred evestigation	at the tim	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the complex	≥ 29b, Signature and title of certifier 29d. Date signed (Mont												
)	2.0			02 Fil	l	MS		DE	29/93		Jur	ne 16	,2008	
9	A		30. Name and address of person Stephen Kill	who completed c	ause of death	(Item 23a) (Type,	Print)	st,	29/93 *201;	Zdgen	ater	MD 2	1037	
	Sta Registi		31. Date filed (Month, Day, Year JUN 1	7 2008	2. Registrar's S	Signature					,			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10 /Medical 4b. Oux or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hours 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Min. Days 1 □ M 2 K F Months District of Columbia 85 Director 579-14-3677 October 8. 1922 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1X Yes 2 □ No Director St. Mary;s Leonardtown Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 39845 Wrinkle Free Lane USA 20650 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Vickers Walter Lambert မ Mary Grace Hardesty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Ignatius Mattingly, Jr. / Son 21560 Joe Hazel Road Leonardtown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Francis Xavier Cemetery June 30, 2008 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P
P.O. Box 270 Leonardtown, MD 20650 Signature of Tineral Service Licensee Approximate Interval Between Onset and Death art1. Inter the disease, or complications that haused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ME MOTHEMAGE (NUME ACMNOID DAYS **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner YEARS MOURYSOM ARTERY ACTLAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Vear 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No the detached 9□Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 □ No certificate 2 No 1☐ Yes 1 TYes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ² this completely filled in by the funeral 27. Manner of Death 1 Denatural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after deatl To the Funeral Director; 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST MARY! MOSPITAL LEONARD TOWN (D'LL WD RATBINDER . 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar **JUN 25**

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <u>Barbara Ann Miller</u> June 22, 2008 /Medical 4:56 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16005 Plumtree Lane Williamsport Washington 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months | Days 1 □ M 2 🕱 F Director 216-30-3151 76 3, 1931 <u>Maryland</u> Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shordical Examiner must be notified at 1 XYes 2 □ No Director Maryland Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16005 Plumtree Lane 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medicai 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If them 27 is marked other the any injury or other traumatic event. the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fortune Odend'Hal, III Francis Violet Coffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Gilmer Siler, Jr., son 5511 Ravenel Lane, Springfield, Virginia 22151 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 6/23/2008 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 23a. Part1. Enter the disease, or complications to Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 40 East Antietam Street, Hagerstown, MD 21740 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ana **Physician** Carethone 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death P.O. | 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this : After thi 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 X Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 41667 Mulour 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Camos theserstown MD 01-1-4 McCorneck

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

Balles

08-04889 Abrianna Mitchell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21653

(- For State Certificate of Death		Reg. N	lo	00 2100
	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Da	y Year	3. Time of Death 0457 hrs
- م	ં વા Examii	ner	Abrianna Elise <u>Mitchell</u>	J	lune 25, 200	8 4c. County of Deat	
!			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo Paninsula Regional Medical Center Salisbury	ocation of Death		Wicomico	"
			r etiinisdia regional wedical denter	If Under 24Hrs. 8	Date of Birth/A	1M/DD/YYYY) 9. B	irthplace (State or
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min.	. Date of Dittif(N	Fore	ign ountry)
	Director		n/a 1 M 2 XF Yrs. 1 19		05/06/20	008	Maryland
	,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	w any	ļ	Tod. State				1 X Yes 2 No
	Maryland 28a-f show d at once.	ē	Maryland Wicomico Salisbury 100 Street and Number 10f. Zip Code		10g.	Citizen of What Co	untry?
\	Mary r 28a ed at	Director	ide. Street and Number			1103	
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho		1100 B Nokomis Ave. 21801 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisp	panic Origin? (Spec	ifv Yes or No-	USA 14. Race - Ame	erican Indian, Black,
1	th wi	Funeral	11. Marital Status 1 X Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	Mexican, Puerto Ri	can, etc.)	White, etc.	African/
8	0 -	Specify:	Allican				
\	21215-0036 Ild be filed within 72 hours after d Mental Hygiene. narked other than "natural", or event, the Medical Examiner m	<u>ē</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Specify only highest grade completed)	on (Give kind of wor		b. Kind of Busines	Ance Lean s/Industry
	2 hou "nati	fed	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired	3)		
	0036 within 7 giene. her than	휠	n/a n/a n/a			n/a	
	5-0C ed wil lygier other he M	Completed	17. Fattlet's Name (First, Middle, Edety	8.Mother's Name (F			
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	36	Marvin Pentiz Mitchell			Conquest	
п.	21 ould d Mer s ma	스	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				
	ages I and 2 shount of Health and Nat. If item 27 is not other traumatic		Alice E. Moore/mother 1100B Nokomi			Oc. Location - City	
	s 1 and 2 of Health of Health of tream		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cermatory or other place) Year and year of the place of Disposition (Name of cermatory or other place)	1 6/30		Salisbur	or MD
	Page nent cant:	1	4 Donation 5 Other Specify: Park				
	Baltimore, permit. Pages 1 a Department of He Important: If its injury or other tr	6	21. ture of Funeral Service Licensee 22. Name and Address Holloway	Funeral	Home Pro	ofessiona	l Associatio
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying,	Hill Rd.	, Sallsk respiratory arres	, shock, or heart	Approximate Interval
,	Physician Medical		failure. List only one cause on each line.				Between Onset and Death
	xaminer		Immediate Cause (Final disease or condition resulting in death) a. Sudden unexplained death in Due to (or as a consequence of):	iniancy			
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated curpute resulting in (agth.) Last Due to (or as a consequence of):				
	ted I Insit	Exa	events resulting in account book				
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	g	X UNPENDED AMENDED 23a,27,28a-f, perME, g8	881 7/24/	08 TT		
	60, ate be ohysici re buri	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	
	rtifica ing pl	ician/	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3	Ectopic pregnan	ncy	Month	Day Year
	Box 68 e death certif the attending ed for use as	sici	1 4 Pregnant at time of death 5 Other (Specify)			1	I
	that the death certificated by the attending detached for use as it	Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
	that the ned by detac	by			1 Yes	2 V No 3 1	Probably 4 Unknown
	aprires en sig	Completed			24a. Was a		e autopsy findings available
	aw re	윤			autops perform	ned? deat	
	Rec The 1 cate 1	ᅣ		(D. 11 (O) -1	1 Y Yes 2	No 1 ✓	Yes 2 No
	tal tian: certifi ector,	B B	25. Was case referred to medical	Other Nursing		Residence 6 C	Other:
	F Si Physic r this	₽	Yes 2 No Inpatient 2 V Ervoupatient 5 Box			ow injury occurred	
	ding J		27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 5 Pending 6/25/08	Yes 2 X No	,		
	SiOl Atten death cetor:	gi	2 Accident S Pending Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office I	building, etc.	unk 28f. Location (S	treet and Number of	r Rural Route Number, City
	Division of Vital Records, P.O. spital or Attending Physician: The law requires that th hours after death. Ineral Director: After this certificate has been signed by rifiled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 X Could not be determined (Specify) residence	ate) I I OO NO ry, MD	komis Ave.		
	Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	_					stated.
	To the Hos within 24 h To the Fun completely	<u>[S</u>	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion	n, death occurred a	t the time, date a	and place, and due	to the cause(s)
	To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier 29c. License				(Month, Day, Year)
		-		.M.E.		June 26, 200	8
			30. Name and address of person who completed cause of death (Item 23a)				
			Tasha Greenberg MD. Assistant Medical Examiner, 111 Penn Street,	, Baltimore, MD	21201		
		State	31. Date filed (Month, 1) Na 3 200 32. Residence dure				
		stra					

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Month **Physician** 2008 14 4:35 A M June Mary S. Minter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Ginger Cove Health Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XX Days Months Hours 22, 1916 Pennsylvania Jan<u>.</u> **Director** 561-14-5492 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21403 4000 River Crescent Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※XX No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗓 💥o White Specify Specify: 2 ¾☐ Widowed 4 ☐ Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Keally ဂ္ Edward Skeehan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles S. Minter III / Son 20783 Sunset Lane Lewes Delaware 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Naval Acad. Cem. 6/27/2008 | Annapolis, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ·Athrosclenotic Heart Di Sea se **Physician** years disease or condition resulting in death) /Medical Examiner Hib Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No Osteobonosi 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1☐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending nours after death.

neral Director: Af
filled in by the fur 1 ☐Yes 2 ☐No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (*Month, Day, Year*) 6/16/08 person who completed cause of death (Item 23a) (Type, Print) Bowle, MP JUN 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2008

Reg. No.

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1615 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examine Anne Arundel Medical Center Annapoli<u>s</u> Anne Arundel If Under 24 Hrs. Hours Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 □ M 2 Director 1941 California July 19, 546-58-3095 Usual Residence of Decedent 66 a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Director Maryland | Anne Arundel Annapolis Health and Mental Hygiene.

m 27 is marked other than "nature..." 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2720 Yeomans Lantern Court 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1959–62 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Administrator Insurance 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be James Mumme Berneice Ventura ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2720 Yeomans Lantern Ct. Annapolis, MD 21401 Beverley Birch / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 6-15-08 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between ant I. E. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. redim Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for Examiner burial-tra Due to (or as a attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown by signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P After this funeral din 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760. P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

be executed requires that the death certificate the Hospital or Attending Physician: n 24 hours after death. le Funeral Director: A sletely filled in by the fu death. within 24

> State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 17 2008

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

PYENSE 2. Registrar's Signature

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

HIGHWAY ANNAPOUS

. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per ft. 9881 7-21-08 vt.
State of Maryland Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** JUNE 25, 2008 11:32 Markley Joyce Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY WMHS - MEMORIAL CAMPUS 8. Date of Birth (Month, Day, Year) Aug 5, 1941 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Months 1□ M 2□ F Yrs Director 212-40-1818 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No Allegany Cumberland MD must be notified Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 416 Seymour Street Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: ¥□ Widowed 4 □ Divorced white "natural" is marked other than "natural raumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 12 <u>homemaker</u> own home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Helen Marie Robertson Roland Cook P 19a. Informant's Name/Relationship (Type. Print)
Patrick Markley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Seymour Street MD 21502 Cumberland son-in-law item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of F
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 6/30/2008 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Dervice Libens 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease I condition resulting in death) Myocardial Infarction 10 Minute **Physician** robable /Medical Due to (or as a consequence of): Examiner Sequentially at constitution of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 □ DOA ဥ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral D completely filledli 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 0 3 2008



GUPTA, SUNIL K., M.D., 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502

D33280

une 26, 200 8

State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 2. Date of Death 3. Time of Death Day Month Physician 19, 2008 June 2:05 p.m. Arnold Richer 01sen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lexington Park

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. St. Mary's 22071 Fox Ridge Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□F Director 309-03-2217 92 11/10/1915 Indiana Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show a or 28a-f sh 1 ☐ Yes 2X No Director Maryland | St. Mary's Lexington Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with anent of Health and Mental Hygiene. An institution 27 is marked other than "natural", or items 23a or sur It item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be runy or other traumatic event, the Medical Examiner must be go "natural", or items 23a dical Exaπiner must t 22071 Fox Ridge Road 20653 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service_Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amil Olsen Agnes Albershen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 is any injury or other trau Gale Canney/Daughter Fox Ridge Road, Lexington Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 07/15/2008 Arlington, Virginia Arlington National 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 20650 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due ιο (or as consequence of): Examine requires that the death certificate be executed physician and is the burial-tran-Due to (or as a consequence of) Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has e 2 autopsy page 2 No certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 1 | Yes 2 No T_o 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Division 5 ☐ Pending investigation within 24 hours after co...

To the Funeral Director; Aft

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H. Bimsly, m.) D21893 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Bunales, M.D. 22335 Exploration II, Suite 1035, Lexington Park, MD 20653 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar JUN 2 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 16:37 PM LAIRD S. OSMAN JR. 06 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hicomico KEGIONAL SALISBULL If Under 1 Year 7. Age (In yrs. last birthday) Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 67 Director 209-32-0544 DEC. 10, 1940 PENNSYLVANIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo SUSSEX DELAWARE SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 'natural", or items 23a 35647 SEA GULL ROAD 19975 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12X/9es 2 □ No If Yes, Give Year or Dates 1958-64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Š Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING PROJECT MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be S. LATRD OSMAN SR. CATHERINE HARRIET MCINTOSH ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. PATRICIA A. OSMAN/WIFE 35647 SEA GULL RD., SELBYVILLE, DE. 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 4 ☐ Donation 5 ☐ Other (Specify) 6/24/08 DELMAR, DELAWARE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cartra 5 5tock **Physician** /Medical Examiner Myram Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): Box 68760. aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred al or Attenative after death.
Interest Director: A' sy filled in by the f 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 6.19-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 MIUSON 57 #605 JOSMII mosum 31. Date filed (Month, Day, Year) 32. R strar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 21659 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** <u>4:1</u>3^{а м} <u>Virginia Lee</u> Parker June 17 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Yea Dec. 10, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1919 1 □ M 2 1 F Months Days Hours 577-18-0710 88 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Extended injust be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11009 Burnley Terrace 20902 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 14. Bace - American Indian. 11. Marital Status Black, White, etc within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Ite once. 1.1 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Lee Engel Florence Bowers ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Parker/Husband 11009 Burnley Terrace, Silver Spring, MD 20902 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) June Date 18. 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cy sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed physician and the burial-tran Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No Ö 9 Unknown 9 I Unknown ۵. Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 s autopsy certificate Vital nours after death.

neral Director: After this certificat
y filled in by the funeral director, p. 1 ☐ Yes 2 Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 ER/Outpatient 3 DOA Certification: To Inpatient ð 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signati 12 2016 GERGIA Are Weater. Name and address of person who completed cause of death (Item 23a) (Type, Print) ICOTRA NO Registrar's Signature State Eur-Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2008 Month **Physician** Emma Grace Pass June 14, 8:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 306 Forest Beach Rd. Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/11/2008 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🔏 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel **Annapolis** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 306 Forest Beach Rd. 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ѽ No If Yes, Give Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mark Thomas Pass Robin Anne Leventry P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark T. Pass/ Father 306 Forest Beach Rd., Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St. Margaret's Church 6/18/08 Annapolis, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Sign work of Funeral Service Licensee MI Ulle 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2No 3 Probably 4 Unknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate Hospital or Attending Physician; funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 X Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who common the common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person who common statement and address of person statement and a se of death (Item 23a) (Type, Print) 200 Fortoes St. Stc 200 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1: 200 M RICHARD **Physician** EDGAR June 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Jan. 18, 1926 Virginia 82 219-12-0345 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show her must be notified at 1 ☐ Yes 25 No Directo Maryland | Montgomery Damascus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 26819 Ridge Road 20872 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married ò 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry th and Mental Hygiene.
It is marked other than "natur: traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Petroleum Business 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wyecliff Richard E11a <u> Melinda Hulver</u> မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 26819 Ridge Road, Damascus, Maryland 20872 С. Richard - Son Gary 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6/25/08 Damascus Meth. Cemetery Damascus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home Nover 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Myocardial infarction Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner coronary ar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence by). that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 ☐ Yes 1 Tyes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Minpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 28b. Time of Certification: 5 Pending investigation Injury 1 Natural 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed physician and as the burial-trans Division of Vital Records, P.O. Box 68760, signed by the at ld be detached for certificate l or Attending Physician: this death. eral Director: A filled in by the fi within 24 hours a

To the Funeral C

completely filled Hospital

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beaver Julia 31. Date filed (Month, Day, Year) State

6 Could not be

determined

29d. Date signed (Month, Day, Year) 29c. License number RES-000 June, 19,2008

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number,

JUN 2 3 2008

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Medical

4 Homicide

(check only

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

Registrar

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 18, 4:55 P M JUNE 2008 ROBERT DANIEL RAMSBURG, SR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) June 2, 1936 7. Age (In yrs. last birthday **Funeral** Days Months Hours 12XM 2□F 72 Director 214-34-0533 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 'Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1

Yes 2 □ No Director Frederick Brunswick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21716 51 Wenner Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Shook Oscar C. Ramsburg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. 51 Wenner Dr., Brunswick, MD 21716 Carol Lee Ramsburg / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 1 ☐ Burial 2 ☑ Cremation 3 □Removal from State Resthaven Crematory 2008 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease or conscicutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi y Cause inal disease or condit in resulting in death UPPER GASTROINTESTINAL HEMOGGHAGE 10 MINUTES **Physician** /Medical 16 MONTHS Examiner METASTITIC SMALL CELL LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has perform 1 Yes 2 No Physician: funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending ↑ Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after de le Funeral Directo letely filled in by t 4 Homicide tale certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 0 2 P31761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 521 W SEVENSH ST. FREDERICK MO O'CONNOT State Registrar

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment c r <i>tificate</i> (of Heal of Dea	th and I ath	Mental Hy	giene Reg. No.	200	8	216	63
	- 69		1. Decedent's Name (First, Middle	, Last)			-			2. Date of De	eath	Yea		3. Time of Dea	ath
	ysicia Medic		Albert Robi	nson,Jr.						June 2	2, ŽÕ		al	4:15P	M
	amin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Tov	n, or Loca	tion of Death	1	4c.	County of D	eath		
		e	Washington Ad	ventist :	Hospita:	1	Tako	ma Pa	rk			Montgomery			
Fun Dire	eral ctor		5. Social Security Number 229–34–4078	6. Sex 1⊠ M 2□ F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Y Months D		nder 24 Hrs. ours Min.	8. Date of Bi (Month, Da Sept.]	rth ay, Year) L6,19	32 V	Countr	ice (State or Fo y)	reign
ъ			Usual Residence of Decedent											-	
rylan how	te		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10	d. Inside City L	
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or 28	e 10	Jire	10e. Street and Number				10f. Zip Co	de			10g. Citiz	zen of What	Countr	y?	
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r deg	er m	by Funeral Director	11. Marital Status	Armed F	cedent Ever in U Forces?	J.S. 13.	Was Decedent If Yes, specify	of Hispani Cuban, Me	ic Origin? (S exican, Puerl	pecify Yes or No o Rican, etc.)	0-	 Race - A Black, W 			
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filed Hygi	i, i		17. Father's Name (First, Middle,	 Last)				18. 1	Mother's Nar	ne (First, Middle	e, Maiden	Surname)			
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at y (at It of It all and It all	mati	ဠ	19a. Informant's Name/Relations			19b. Mailir	na Address (Si			Washing Iral Route Numb	,	r Town. Stat	e. Zip (Code)	
Mar d2s thar thar 7 is	trau		Clarine Daniels											,	
Heal Heal	the		20a. Method of Disposition	,	20b.	Place of Dispo cemetery, crei	sition (Name of	tree!	E Noun	t Raini Date	er, 1 20c. Lo	4D↓ 20 cation - City	712 or Tow	n, State	
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DatuillOTe, Intel yiall G 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show	ini Tuju		4 □ Donation 5 □ Other (S		110					4 South					
Deprir Deprir	any				.78 MD	W	illiam	M. Jo	ohnson	& South	maii Funei	al:,	rra	nklin,	va.
			23a. Part1. Ever the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not ent	er the mode o	f dying, suc	ch as cardia	or respiratory	arrest,			Approximate Interval Betwee Onset and Dea	en
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w requires that the death certific been signed by the attending p	r use	Physician/Me	23b. Was decedent pregnant		utcome pf pregr birth 2 ☐ Fet		☐Ectopic pregr	nancy			1 4	23d. Date of		,	
e dea	og pe	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (speci					Month	L	Day Yea	,
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19 P C	neral		27. Manner of Death 1 □ Natural 5 □ Pendin		e of Injury onth, Day Year)	28b. Time o Injury	f 28c.	Injury at Work?		28d. Describe	how injur	y occurred			
ath.	ne fu	atic	2 ☐ Accident investig	jation			М	1 ☐ Yes	2 🗆 No						
r Atte	by tl	i ii	3 Suicide 6 Could a 4 Homicide determ	inod 28e. Plac	ce of injury - At h	nome, farm, sti vify)	reet, factory, o	ffice		28f. Location City or To	(Street an own, State	d Number o	r Rural	Route Number	5
italo rs aft	led ir	Certification:	••												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 ч	Medical	29a. Certifier (Check only one) 1 Certifyir 2 Medical	g Physician: To the Examiner: On the	ne best of my kn basis of examin unner stated.	owledge, deat ation and/or in	h occurred at to estigation, in	he time, da my opinio	ate and placen, death occ	e, and due to the urred at the time	e cause(s) e, date and	and manne d place, and	r as sta due to	ated. the cause(s)	
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			30. Name and address of person					C	mo = 1.	.14 1/1	20	770			
100	Sta	0	Chandra Korapat 31. Date filed (Month, Pay, Year)		7207—B I Redistrar's Sign		rarkw	ay G	reenbe	ert, Md.		770			
	- Jia		JUN	9 2008	Ela	Bo	Acarto a								

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

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within 2 To the

State

Medical

29a. Certifier

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

P.O BO p 1733 SACE BULLY UND 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21665 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** June 17, 2008 Samuel Relos 7:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Cherry Lane Nursing Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 19, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. *Country)* **Virginia** 1 M 2 ☐ F 88 579-05-5513 **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the "hadical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George's Laurel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20708 13303 Adams Place Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Ny Wes 2 If Yes, Give 2 🗆 No 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐Yes 2 No Specify: 2 3 Widowed 4 □ Divorced Year or Dates: 1940-45 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be a Department of Health and Mental Important: If Item 27 is marked o Thano Trahadias Angelo Relos ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 Pinecrest Circle, Silver Spring, MD 20910 Theone Relos/Daughter injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date June 18, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis of ddd cospilars Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) over 1 year **Physician** Cancer of Lung with Metastases /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Parkinson's Disease 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 2 No 1 ☐ Yes 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number N.O June 18, 2008 9+1 D24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 Laurel-Bowie Road, #208, Laurel, MD 20708 Syed A. Ali Sadiq, MD 31. Date filed (Month, Day, 32. egistrar's Signature 19 State 2008 Registrar

			1 = For State Registrar	State of Maryland		artment of H tificate of L		ental Hygie Reg.	- 2HH)	3 21666
	Physici	an	Decedent's Name (First, Middle, Last	111 0				2. Date of Death Month	Day Year 7 2000	3. Time of Death 7 222 P M
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	Director		Usual Residence of Decedent	- 61	Yrs.			Hug 5,1	943 5	oford, DE
	Marylar a-f shov fled at	ctor	10a. State 10b. County	10c. City,	Town or Low	exal				10d. Inside City Limits 1 Yes 2 □ No
	h with the 23a or 28 st be noti	Funeral Director	10e. Street and Number 824 Perkins S	treet		10f. Zip-Code	13	10g.	Citizen of What Co	untry?
980	De filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	ify Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
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Man	nd 2 suff and 27 ls 27 ls r trau		19a. Informant' Name/Relationship (Ty	pe. Print)	19b. Mailin	PerKins	and Number or Rural	Route Number, C	ity or Town, State, Z	Pip Code)
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 2 4 Donation 5 Other (Specify)	Removal from State	metery, gen	sition (Name of natory or offer plac	1	te 200	Location - City or	Town, State
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	Physician		23a. Part 1. There the disease or comp shock or heart failure List only of immediate Cause (Final disease or condition	- 1	Do not ente	1	ig, such as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque		1 1 4				Services State, Zip Code) 9993 City or Town, State 19933 Approximate Interval Between Onset and Death 3 Ays 4 Clays The of delivery of the course of death? 3 Probably 4 Unknown
	ted	Examiner	Sequentially list conditions, if any, leading to included cause. Enter Underlying Cause (Disease or injury	o. Unito (or as a nonseque	india tuthi	im	31101	~		Mess
8760,	cate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
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rds, P.O.	w requires that the been signed by should be deta	þ	Part II. Other significant conditions co	ntributing to death but not resul	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	10	
Division of Vital Records,	has ge 2	Completed		-				24a. Was an autopsy performed	pnor to	topsy findings available completion of cause of
Vita	sician: The certificate director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ⊠ npatient 2 ☐ E	R/Outpatient	t 3 □ DOA Othe	26. Place of Death (er: 4 ☐ Nursing Home		e 6 ☐ Other (Spec	cify)
ion of	ding Phys th. After this funeral d		27. Manner of Death 1 Natural 5 Pending investigation		28b. Time of Injury	Work		3d. Describe how	injury occurred	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical C		sician: To the best of my knowle iner: On the basis of examinatio and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of confifier	MA Da		29c. License		29d.	Date signed (Monti	
	(4)		30. Name and address of pason who c	ompleted cause of death (item	23a) (Tyne		-000	(16/15/2	2008
_			Jeremy Gotz			1	600 N	orth Wolfe	St, Baltimo	ore, MD, 21287
	Sta Registr		31. Date filed (Month, Day, Year) 3 20	32. Registrar's Signatur	O A	geret.				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008

21667

				Cert	tificate of	Death	Re	eg. No.	
	Dii-		Decedent's Name (First, Middle, Last)			_	2. Date of Deat	_	3. Time of Death
- 2	Physic /Medi		Elve L. Steel	0			June	Day 5	2000 0410
ز	Exami		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Loc	ation of Death	4c. County	of Death
			baysiau aruunt	R		Lexing	tont	JRK	St. Mari
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		3/8-36-1/20 /9	Yrs.			Ju1y 15		Maryland
	pu ≱∷		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Loca	ation				10d. Inside City Limits
	lanyla eho	5		_					1 ☐ Yes 2 ☒ No
	he N 28a-1	ect		exingto	T		T		
	with the	ä	10e. Street and Number		10f. Zip Code		10	Og. Citizen of W	
	8 23	Funeral Director	21412 Greatmills Road	0 40 111		653	" M N		d States
	item item	Ë	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ★ No	,S. 13. W	Yes, specify Cub	Hispanic Origin? (Spec ean, Mexican, Puerto F	lican, etc.)		e - American Indian, k, White, etc.
)20	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a4 ehow other traumatic event, the Mexical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☒ Divorced Year or Dates:	1[□Yes ⊉ QXNo	Specify:		Specify:	White
21215-0020	ture H	B	15. Decedent's Education	16a. Decede	ent's Usual Occup	pation		16b. Kind of Bu	siness/Industry
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212	with iene. thar	E	Elementary/Secondary (0-12) College (1-4or 5+)	Homema				Own Ho	me.
	Hygir Hygir ent, II	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M		
Maryland	ould be Mental arked o	To B	Ed Garney			Grace A	tchinso	n	
a _Z	2 should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	t and Number or Rurel			State, Zip Code)
	1 and 2 Health a em 27 is		Vicky Marie Wagner / Daughter	368 Th	underbi	rd Ave. N.	W. Palm	Bay, F	L. 32907
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other ti once.		20a. Method of Disposition 20b. P	Place of Disposi					City or Town, State
٤	g <u> </u>	19 5	1 Li Buriai 2 Lacremation 3 Li Removal from State			Cremato 6	/28/08	Charle	tte Hall, MD.
≣	permit. Pag Department Important: It any Injury o		21. Signature of Funeral Service Licensee		Name and Addre				
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89	ficate phy is the	n/Medical	resulting in death) Last	r as a conseque	ence of):				
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ă	eath atte	cia	Part II Other simplificant and distance and the desired				not Distant		
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of Vital Records,	uires n sign						24a. Wes er	autopsy	24b. Were autopsy findings
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Ē			25. Was case referred to medical			00 51 / 5 //		s 2 🗹 No	1 ☐ Yes 2 ☐ No
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9	ding Ih. After	힐	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		rk? Yes 2 □ No			
ĪSĪ	Attending or death. sctor: After by the fune	lica	3 Suicide 6 Could not be 28e Place of Injury - At ho	me, farm, stree			3f. Location (Str	eet and Numbe	or or Rural Route Number,
Division	of or Attends after death	Certification:	4 ☐ Homicide determined building, etc. (Specify	1)	.,,		City or Town,	State)	
	spita nours nerel		29a. Certifier 1 CertifyIng Physician: To the best of my know	wledge, death o	occurred et the tir	me, date and place, ar	nd due to the ca	use(s) and man	ner as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	edical	(Check only one) 2 Medical Examiner: On the basis of examinat and manner stated.	ion end/or inves	stigation, in my o	ppinion, death occurred	d et the time, da	te and place, a	nd due to the cause(s)
	of the control of the	M	29b. Signature and title of certifier		29c. Licens	se number	29		(Month, Day, Year)
	2 - 0		No Mader To	avakal.	1 1	11978		6-2	7-2008
			30. Name end address of person who completed cadse of death /Item	23a) (Type. Pr	rint) O -	111/0		٨	,
			30. Name end address of person who completed callse of death (Item	X.9	3/2/	A BOWI	e 1	W) 2.	2716
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signal	ture					
	Registr	ar	JUN 3 0 2008	and a					
DHI	MH 16 Rev 6/9	5	7	case d					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 8:15 AM 2008 GERALDINE MAE STARLEPER 20 line 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN Social Security Number 218-24-1564 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex B. Date of Birth
DE*(MontingDay, Yell* 928 1 □ M 2 🗓 F Months Days Hours Min. Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Y Yes 2 □ No WASHINGTON HAGERSTOWN MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's 21713 U.S.A. 55 E. WASHINGTON STREET, APT. 613 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLIFFORD PHILLIP DERR VIRGIE ELEANOR DEWITT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 N. VERMONT STREET, WILLIAMSPORT, MD JUDY A. MYERS, DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State BOONSBORO CEMETERY 6/23/2008 BOONSBORO, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility 7606 OLD NAT'L PK. BAST-STAUFFER FUNERAL HOME, P.A. BOONSBORO, MD 21713 at 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or left tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cose (Final ACUTE RENAL TAT WIRE disease or condition resulting in death) Due to (or as a consequence of): CIRRITOSIS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEPATIC EN CEPHALOPATHY Due to (or as a consequence of) DIABETES MELLIM IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2-No 2 🗆 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

be execu Box 68760 P.O. Records. Division of Vital

burial-tran aftending physician for use as the buria signed to page 2 certificate this After t Hospital or Attending death. neral Director: / e Funeral E

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d other than "natural", or items 23a or 28a-f shovevent, the Medical Experience, unit by pathled at

Department of Health and Mental Hygien, Important: If Item 27 is marked other that any injury or other traumatic events.

Physician

/Medical

Examiner

72 hours after

3altimore, Maryland 21215-0036

34-4

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID MUYAKO 31. Date filed (Month, Day, Year

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a, Certifier

WIRESON 32. Bristrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ANTIETAN

10062006

6/22/08

HAGEN: TOWN

29d. Date signed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 14, 5:35 A M Patricia A. Salvatore June 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 578–48–0678 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕱 F 71 Yrs. Mar. 26,1937 Pennsylvania Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Anne Arundel MD 1 ☐ Yes 2X No Director Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2700 South Haven Road 21401 USA 238 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of College (1-4or 5+) Elementary/Secondary (0-12) MD College Park Budget Analyst other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Sungenis Lena Canino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Neill/ Cousin & P.R. 574 Strawberry Avenue Vineland, NJ 08360 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place Lakemont Memorial Gardens June 18, ò 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Fun ral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 110mase 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) apoliac **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 3 ER/Outpatient 3 DOA 27. Manne of Death 1 Natural funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation nours after death, neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) To the Hospital or within 24 hours aft To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29c. License number ana d cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

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1 7 2008

31. Date filed (Month, Day, Year)

egistrar's Signature

			- negistial	State of Maryland	/ Depa	rtment of F tificate of	lealth and M Death		1eg. 140.	3 21670
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Bertie	Lee		Schwar	tz	2. Date of Dea Month June	15, 2008	3. Time of Death 9:10 aM
No. of the last of	Examir	er	4a. Facility Name (If not institution, give str Sunrise Assisted I	iving		Columbi			4c. County of De Howard	
	Funeral Director		5. Social Securify Number 6. Sex 1 Usual Residence of Decedent	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3/29/19	9. B 22	irthplace (State or Foreign Country) VA
	Maryland f show led at	jo	10a. State 10b. County MD Anne Arun		Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the lor 28a- e notifi	Funeral Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What C	Country?
	ath wi	ral	1117 Cherry Pt. Rd			207			USA	
Maryland 21215-0036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 33CM/Vidowed 4 ☐ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of H fYes, specify Cuba □Yes 🏖 📆 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: Wh	ite, etc.
15-0	permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", a any injury or other traumatic event, the Mudical Evan once.	Completed	15. Decedent's Educa (Specify only highest grade of	ion ompleted)	16a. Deced	lent's Usual Occup	ation during most of worki f)	ing	16b. Kind of Busines	s/Industry
212	s withir jiene.	gmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Estate E	_		Owner/ Ope	erator
nd	be filec tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		*	
ryla	hould Ind Men	ပ္	Francis Marion Spur 19a. Informant's Name/Relationship (Type		10b Mailin	a Address (Street	Susie Be		man r, City or Town, State,	Zin Codo)
Ma,	alth ar 27 is er trau	1 3	George Heine Jr.	Son		Cherry F			er, MD 207	
Baltimore,	ges 1 at of He If item or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rer	20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other place	e) [Date	20c. Location - City of	r Town, State
Iţi	urtmen urtmen urtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			d Cemeter			Galesville	
Ba	Impo any any	5 6	1 7 7. Charles of the land service Liverisee					•	uneral Hor , MD 21401	•
	Physician	0 1	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death 10 yrs.				
T.	/Medical Examiner		resulting in deality	Due to (or as a consequer	nce of):					
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68760,	ifficate be executed g physician and as the burial-transit	edical E	d.							
P.O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2∑No 9 □ Unknown	If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗆	Ectopic pregnance Other (specify)	y		23d. Date of d Month	elivery Day Year
Records, F	w requires that s been signed I should be deta	þ	Part II. Other significant conditions contri	outing to death but not resulting	ng in the un	derlying cause give	en in Part I.			to the cause of death? Probably 4 ☐ Unknown
al Reco	i: The law ricate has be	Completed						24a. Was a autops perforr 1 □ Yes	sy prior to	
of Vital	nysician: Th nis certificate director, pag	B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No Hos	pital: 1 ☐ Inpatient 2 ☐ EF	2/Outpotion	Othe	26. Place of Death		e) ence 6 ÃOther (Sp	Asst. liv
	ding Phy n. After this funeral d	on: To	27. Manner of Death 12☑Natural 5 ☐ Pending		Bb. Time of Injury	28c. Injury Work			ow injury occurred	ecity) 1330 1
Division	or Atten after death Director: in by the	Certification:	2 Accident investigation	28e. Place of Injury - At home building, etc. (Specify)		M 1 🗆	Yes 2□No	28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dire completely filled in I	Medical (29a. Certifier (Check only one) XXXCertifying Physic 2	ian: To the best of my knowle : On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occurr	and due to the ded at the time, d	ause(s) and manner late and place, and du	as stated. ue to the cause(s)
	Voith Com	Σ	29b. Signature and title of certifier	M.D.		29c. License		2	9d. Date signed (Mor	
		-	30. Name and address of narrow who same	0	Pal /Tima P	D565			June 16,	, 2008
0	16		30. Name and address of person who comp Harry Li 8600 Snowd				, MD 2104	5		
	Sta Registra	te ar	31. Date filed (Month 17 200	32. Figistrar's Signature	× /	andi)				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25,2008 9:40P JUNE **Physician** DONALD WISHART STRASBURG /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ST.MARY'S CHARLOTTE HALL CHARLOTTE HALL VETS. HOME Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months Days Hours **Funeral** 1√ M 2□ F MICH. 9-13-1924 83 365-22-5812 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State Item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No CHARLOTTE HALL ST.MARY'S Director MD. 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mential Hygiene. int: If Item 27 is marked other than "natural", or Items 23a or 3 U.S.A. 20622 29449 CHARLOTTE HALL RD. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status 1 Dyes 2 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 No NAVY 1 NO NAVY 1 Never Married A Married 1 ☐ Yes 2 No Specify Specify: WHITE Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NAVAL RESEARCH College (1-4or 5+) Elementary/Secondary (0-12) U.S.GOVT. ENVIROMENTAL STUDIES 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDITH WISHART HERMAN STRASBURG ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 EMERALD HILL DR. FT.WASHINGTON, MD. 20744 DONNA STRASBURG-SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERVIEW CEMETERY 7-2-08 ST.JOSEPH, MICH 22. Name and Address of Facility 21. Signature of Fundal Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, aused the death. 23a. Part1. Enter the disease, or complications if shock, or heart failure. List only one cause Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death signed by the attendin the detached for use 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? gignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division or Vital Records, 2 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy cate has t performed' 1□ Yes 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical examiner? Be Other: Hospital: 1 ☐ Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Herty 32. Registrar's Signature 31. Date filed (Month) Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Joyce Elaine Tivnan $2\check{1}$ June 2008 2:43 P^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's Mechanics ville 30539 Point Lookout Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🖾 F 303-28-4992 3, 82 1925 Indiana Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director MD St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30539 Point Lookout Road 20659 United States Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify Specify: à 3 X Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Labart Unknown John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 Debra Drive, Waldorf, Maryland 20601 Royce Tivnan (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cem. 6-23-2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee #M01206 Kyle Simons 22955 Hollywood Rd., Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury Examine death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No has e 2 page certificate 1∐ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2□ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Certification: Division To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After (Month, Day Year) 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29c. License number / 4 285 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25365 Point Lookout Road, Leonardtown, Maryland 20650 William D. Boyd II, M.D., istrar's Signature 31. Date filed (Month, State 3 2008

Registrar
DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 am 2008 DANIEL WAYNE THOMAS Une 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Pla If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 10-5-1946 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours INDIANA M 2□ F 307-48-1489 61 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No NEWBURG CHARLES MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20664 9700 ORLAND PARK ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Allied Tolless 2 □ No NAVY | ITYES 2 □ No NAVY | ITYES, Give Year or Dates: 20yr(ret) 1 □ Yes 2 ▼ No 1 ☐ Never Married 2 ☐ Married WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOATSWAIN MATE 1ST CLASS RET.U.S.NAVY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILMA MAE CRODDY JACK WAYNE THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O.BOX 286 LA PLATA, MD. 20646 LYNN THOMAS-DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State METROPOLITAN CREMATORY 6-28-08 ALEX., VA. 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licens M00479 LA PLATA, MD. 20646 23a. Part 1. Inter the disease, or complications to a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Schandly life of differential if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Exa, in a rount to motified at

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271 State Registrar

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29a. Certifier (Check only one) 29b. Signature and

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number P006/652 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person cause of death (Item 23a) (Type, Print)

KATYAL 31. Date filed (Month, Day, Year)

6 POST OFFICE ROAD SUITE IDI WALDORF, HD 20602

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/Iand wild be file Mental Hy arked oth		9	Andreas	Strie	ge1				Paula	Unknov	m			
Mary d 2 sho th and 1 T Is ma			19a. Informant's Nar	me/Relationshi	p (Type. Print)		19b. Mail	ng Address (Stree	et and Number or	Rural Route Nu	ımber, C	ity or Town,	State, Zij	p Code)
and and a salth			John Emil	Ujhaz	y/Son		7414	Lake G1	en Drive	G1enn	Dake	, Mar	y1an	d 20769
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Baltimore, IMaryiar permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic examples.	ouce.		21. Signature of Flux	eral Service L	cense		2	2. Name and Add	ress of Facility	DeVol Fu	iner	al Hon	ne	
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Attending Physic death. rector: After this by the funeral of			1 🖾 Natural	5 Pending	(Mo	onth, Day Ye		W	ork? ☐Yes 2 ☐ No	200. 00001	100 11011	injury occur	i cu	
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after Dire		Certification:	4 ☐ Homicide	determir	bui bui	lding, etc. (S	At home, farm, st pecify)	, , , , , , , , , , , , , , , , , , , ,		City or	Town, S	itate)	or or riar	a
spita ours neral	19		29a. Certifier	1 X Certifying	Physician: To t	he best of m	y knowledge, dea	th occurred at the	time, date and pla	ace, and due to	the caus	e(s) and ma	anner as :	stated.
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to		Me	29b. Signature and t	itle of certifier			· · · · · · · · · · · · · · · · · · ·	29c. Lice	nse number		29d.	Date signe	d (Month	, Day, Year)
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7		-	30. Name and addre	ss of person w		use of death	(Item 23a) (Type	Print)						
الم			C. Vergar		es MD	4041 1	Povdermi	,	Calverto	n. MD 2	0705			
	State	9	31: Date filed (Month		32.	Registrar's	Signature	Iwau						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year Day **Physician** WILLIS 11:45 P M JUNE WATSEKA 2008 7 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON BALTIMORE MANOR CARE RUXTON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months Maryland May 10. 1921 155-26-2284 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Yes 2 No Funeral Director Maryland Harford Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21009 20 Box Hill South Parkway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 □Yes 2 No Specify. ģ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "n r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Ret Seamtress Sewing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental F George Robert Jones Mary Jones (Hackett) Pages 1 and 2 should nent of Health and Men ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5572 Nettlebed Court. Columbia. Maryland 21045 Milton Robert Willis (Son) Department of Health Important: If item 27 any injury or other troone. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 6/19/2008 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 21. Signature of Funeral Service Licensee dian 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NEOPLASM OF Immediate Cause (Final MALIGNANT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to for se's consequence off requires that the death certificate be executed Exami physician and the burial-trans Due to (or as a consequence of): physician Physician/Medical attending 35 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

Box 68760. P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: After this (funeral din

within 24 hours after deau...

To the Funeral Director: After the funeral Director of the funeral or the funera

State Registrar

31. Date filed (Month, Day, Year) JUN 2 0 2008

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be determined

CEONARD RICHARDSON M.D. 1838 GREENE TREE ROAD #300 PILESVILLE MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MP

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated.

29c. License number

057722

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

JUNE 19 2008

State of Maryland / Department of Health and Mental Hygien [] [] [

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 17,2008 Year **Physician** Elizabeth Waks 7:30 Pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery National Lutheran Home 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF 256-40-5948 76 Yrs. Georgia Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Iteme 23s or 28s-f show the Medical Examinar must be notified at Rockville Md. Montgomery 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9701- Veirs Drive 20850 TISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Marriott 12 is 1 and 2 should be filed in Health and Menta! Hygie Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Agnes Pearson Walker Reid 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) - Husband Nelson Waks 13700 Berryville Rd., Germantown, Md. 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Its
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bellevue Mem. Gardens-6/23/08 Augusta, Ga. 22. Name and Address of Facility 2222 Wisconsin Ave., NW 21. Signature of Funeral 50 Hysong Washington, DC 23a. Part1. Enter the disease, or complio shock, or heart failure. List only one Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician LOUNS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner on Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physicien for use as the buria Iclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ icate has been sig 7, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate ! 1 Yes 2 No 1 Yes 2 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 70 3 DOA this 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 Yes 2 No investigation M 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nause(s) and manner as stated 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 121726 areshow une 18,2008 B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701- Veirs Dr., Rockville, Md. Dr.Charles Karesh 31. Date filed (Month, Day, Year) 32. Registrar's Sign State

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6/15/2008 Year **Physician** 0220 Helen H. Witte /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) 2/11/1922 Birthplace (State or Foreign Country)
 NJ If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🖼 F 154-16-8322 86 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 □Yes 🍇 🔼 No MD Anne Arundel Annapolis Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 USA 1926 Fairfax Rd. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 € No Baltimore, Maryland 21215-0036 White 1∐Yes 2**XX**No Specify: <u>ک</u> 3 KWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Navy Admin. Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hasia Paroby Maximous Hmily ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 907 Overbrook Rd. Baltimore, Md Daughter Eileen Witte 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 6/20/2008 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 1 12 Ridgely Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) P.0. ed by the a a∏Unknown 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 1 ☐ Yes 2 **∃**No or Attending Physician: After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 mpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ٤ 31. Date filed (Mo State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death Month Year **Physician** 2008 542 PM 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F Hours 214-72-0016 8/30/1960 Marvland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Edgewater Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I ment of Health and Mental Hygiene.
Intel fitem 27 is marked other than "natural", or items 23a or in yor other traumatic event, the Medical Examiner must be not 3321 Cedar Drive 21037 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Software 4 vears Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth T. Wood, Sr. Evelyn F. Leichsenring ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Wood/ Wife 3321 Cedar Dr., Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. WBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Our Lady of Sorrows 6/17/08 West River, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of Funeral Service Licenses 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VRACS CINCY -una disease or condition resulting in death) /Medical Due to (or as a vor sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Completed by Physician/Medical Examiner Cause (Disease of Injury) that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NUSPICE 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Feath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: v 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check o and manner stated. 29b. Signature and 29c. License number of certifie 29d, Date signed (Month, Day, Year) D65272 611610 o completed cause of death (Item 23a) (Type, Print) 12 vid Suite 300 Annigilo Mo 2140 900 Best 31. Date filed (Month, Day, Year) ■egistrar's Signature Registrar JUN 1 7 2008

10 State 30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

Assistant Medica Examiner

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

June 27, 2008

Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Mayford Edward Weslow, Jr. June 25 9:35 P 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Allegany Cumberland <u>The Kensington Algonquin</u> If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day,) Mar. 31 9. Birthplace (State or Foreign Country) Maryland . Age (In yrs. last birthday **Funeral** 1**⊠** M 2□ F 212-24-1983 1929 79 Mar. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ral", or items 23a or 28a-f shor Examiner must be notified at 1 ¥Yes 2 □ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 21502 732 Hunt Terrace Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1949 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 1952 the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Service Station/Towing Owner/Operator snould be file of the and Mental Hye 7 is marks traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked of any Injury or other traumatic ew Mayford Edward Weslow, Sr. Orpha Berkley ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8500 Brentford Ct., Waxhaw, NC Carol Muscarella Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Jun 30 08 Rocky Gap Vet Cem. Flintstone, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hafer Funeral Service, PA 1302 National Hwy., LaVale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Metastatic Adenocarcinoma one year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760 attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 No 1∏ Yes Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Assisted Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Living 1 Yes 2 No Hospital: 3□ DOA Certification: To 1 🔲 Inpatient 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral I Medical 29a. Certifier completely and manner stated. within 2 29b. Signature and title of perticies 29c. License number 29d. Date signed (Month, Day, Year) D33417 (Maryland) June 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. James R. Moen, MD, 1068 National Hwy., LaVale, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State in It factor JUL 0 3 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 21682 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUN **Physician** Day 4 2008 KAYDEN ETHAN WINTER 2:53 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY **BETHESDA** NATIONAL NAVAL MEDICAL CENTER 8. Date of Birth (Month, Day,)
MAY 27, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 X M 2 □ F 2008 VIRGINIA NONE Director 28 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 XNo Director **VIRGINIA** FAIRFAX LORTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7647 HIGHLAND WOODS COURT APT. B3 22079 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NICHOLAS PAUL WINTER ANDREA FOX ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREA FOX (MOTHER) 7647 HIGHLAND WOODS COURT APR. B3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State POTOMAC CREMATORY JUNE 29,2008 DALE CITY, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CUNNINGHAM—MOUNTCASTLE FUNERALHOME 13318 OCCOQUAN ROAD WOODBRIDGE, VIRGINIA 22191 Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** EXTREME PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1☐ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 X Inpatient Certification: To this in by the funeral 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital filled 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD048338-L (PA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER 2 MAUREEN L. TATE
31. Date filed (Month, Day, Year)
JUL 0 3 2008 BETHESDA MD 20889-5600 MC USA 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 3 per dr., 9881, 07/03/03/03/11 and Mental Hygiene Reg. No. 2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1234 BRENDA LEE HOLLINGSWORTH WISE 06/17/08 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BERLIN WORCHESTER ATLANTIC GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01/01/65 7. Age (In vrs. last birthdav) 5. Social Security Number Months 1 M 2 X 43 Yrs. VIRGINIA 229-11-6261 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1∏Yes 2∏No WORCHESTER POCOMOKE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 101 LAUREL ST. 21851 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 LABORER DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE GODWIN FANNIE MAR BATLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NEW CHURCH, VA 23415 THOMAS HOLLINGSWORTH, BROTHER P.O. BOX 133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DEA'S CHAPEL CEM. 06/21/08 HORNTOWN, VA 22. Name and Address of Facility COOPER & HUMBLES FUNERAL CO. 21. Signature of Funeral ACCOMAC. VA 23301 rt 1. Enter the dis Ase, or comparation shock, or heart fail and List only one comparations. or complication, that the sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest it only one cause on so h line. Approximate Interval Between Immediate Cause (Final Pancreatiti disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 🗌 Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, I'm Modical Examiner must once.

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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physician and the burial-transi attending p for use as After this certificate has been signed by the a funeral director, page 2 should be detached to

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral di ector, p

ا المركزين

within 24 hours a

To the Funeral I

completely filled

State Registrar

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐Yes 2XNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

(Check only one)

29c. License number 00064120 29d. Date signed (Month, Day, Year)

06/17/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGH 9733 Healthway Drive Berlin MD 21811 Atif Zeeshan

31. Date filed (Month, Day, Year) 0 3 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28y, 2008 6:00A M **Physician** Jurte Ruth Frances Argent /Medical 4a. Facility Name (If not institution, give street and number)
Bethany Lane Assisted Living 4c. County of Death
Baltimore 4b. City, Town, or Formion of Death Examiner 7. Age (la ws. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign sept. 20,1914 Washington, DC 9. Birthplace (State or Foreign 5. Social Security Number 578-03-6687 **Funeral** 1 M 2 F Days Hours Director Usual Residence of Decedent 10a. State Baltimore 10c. City, Town or Leastion Cott City 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In a Medical Examinat must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 21043 10g. Citizen of What Country? 10e. Street and Number 4910 Washington way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces!

1 Yes 2 No
If Yes, Give Black, White, etc. should be filed within 72 hours after on Mental Hygiene. marked other than "natural", or ite 1 Never Married 2 Married White 1 □Yes 2 No Specify. þ Specify. Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1N9/Å+) Elementary/Secondary (0-12) Waitress David Argent Rest. 18. Mother's Name (First, Middle, Maiden Surname) Ruth HeIIIn 17. Father's Name (First, Middle, Last)
Francis Vallandingham 86 ပ 19a. Informant's Name/Relationship (Type Print) Harrietta Keeney/ Sister 19b. Mailing Address (Street and Number or Bura) Floute Number, City or Town, State 276343 20a. Method of Disposition

1 ☐ Burial 2 ☐ Stormation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of West ArundelCrematory 7/ 7/08 Odenton, Maryland 21 Signature of Funeral Service Lice AMBROSE FUNERAL HOME, Inc. 1328 Sulphur Spring RD. Arbutus, Maryland 21227 attur an Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease or Injuly that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but ngt resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown Completed 6 nilleto 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 1 ☐ Yes 2 No 1 ☐ Yes 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Wother (Specify 1 ☐ Yes 2 🖳 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certified

State

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Registrar

DHMH 17 Rev 1/2001

30 Name and

31. Date filed (Month, Day,

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address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

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32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Demetrius Antonio 11:44 24, 2008 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Feb 25, 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Min. Hours 1 → M 2 □ F 242-19-1729 46 North Carolina 1962 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be natified at 1 Yes 2 □ No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Goodrich Road 21401 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No à Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Griffin ၉ Lula Mae Adams Goodman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susie S. Adams / Wife 11 Goodrich Rd. Annapolis, MD 21401 20b. Place of Disposition (Name of New Middle Swamp 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6-29-08 Corapeake, NC 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 21. Sign wre of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home P.O. BOx 296 Gatesville, NC 27938 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetland Death Immedia e Cause (Final ertorated Physician duo denal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transi requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Dav Yea 5 Other (specify) signed by the a d be detached fo 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has I page 2 s autopsy performed? certificate 1 XYes 2 No 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred I or Attending Fatter death. Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier your Beck, MD D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sional Bech, 170 2001 (Webical Parkway 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 21686 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 4, Broadwater 2008 12:15 pm Blanche Freda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 929 Lance Avenue Essex 8. Date of Birth (Month, Day, Year) 4/28/1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. **Funeral** Min. Hours Months 1 □ M 2 X F 214-34-1845 Director Maryland 73 Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it would be not the configuration of the configuration of the configuration. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code S. A. 929 Lance Avenue 21221 U. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify \$ 34 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Savilla Wilt ပ Robert Broadwater 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7109 Cunning Circle Middle River, Maryland 21220 Linda Butta (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 368 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery Overlea, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Known Examiner per ren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for s a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has e 2 s autopsy performed? 1 Yes 2 ANo s certificate ha Hospital or Attending Physician: : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of Injury . Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASREM: 709. BASTERN BLVD - MD - 21221. 10 709.

DHMH 17 Rev 1/2001

State Registrar 32. Hegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar 21687 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Emma Gertrude Bell July 5, 2008 9:15AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban_Hospital Bethesda
If Under 1 Year | If Under 24 Hrs Montgomery 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Director 578-09-5921 May 15, 1916 Virginia Usual Residence of Decedent the Maryland 10a. State 10h County 10c, City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exercises must be redified at 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7008 Bradley Boulevard Funeral 20817 death <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after of lealth and Mental Hygiene. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No <u>م</u> If Yes, Give Year or Dates: Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Part Owner Washington Coal Company 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George Washington Bell Florence Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
795 Harness Creek View Drive
Annapolis, Maryland 21401

ce of Disposition (Name of Date 20c. Location - City or Town, State) 19a. Informant's Name/Relationship (Type. Print) Health lem 27 i Elizabeth B. Rounsaville/ Niece Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition jo := ncoln Cemetery 15, 2008 Brentwood, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, or copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should h Leukocytosis Completed 24b. Were autopsy findings available prior to completion of cause of death? (Possible) Pneumonia 24a. Was an s certificate has b lirector, page 2 s autopsy perform 2 No 1 ☐Yes 2 MNo or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thir funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 X Natural ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 066066 MD person who completed cause of death (Item 23a) (Type, Print) 15 ans mor 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month kegistrar's Signatur State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 15 per fb 881 7-7-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 21688 Certificate of Death Reg. No.2 () () 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Zoo Pear **Physician** Sarney 2:00 PM Tuly 2 lueste erald /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore christ TOWSON topice If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Wast Ulmainia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 212-38-4350 March 26, 65 Months 1 M 2 □ F Yrs **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified a once. 1 ☐ Yes 2 No osedale Funeral Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United State 21237 100 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Black Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, PO NOT use retired) altimore Elementary/Secondary (0-12) College (1-4or 5+) Water abover + Waster Water 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OUSINS 252 sarney 2 cca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary land 21237 Barney lma Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore armel Com 7/12/08 Mount Name and Address of Facility ture of Funeral Service Licensea. ALVIN L. Willer 270 Fredhilton down L. M Balto, MO 2/229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lie to (or a a consequence of): 1605 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examine executed burial-trar Due to (or as a consequence of): that the death certificate be Physician/Medical the attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the detached Ö 9 Unknown 9 Unknown þ ٦. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Completed by Record 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? 1 Yes 2 Who Vital 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPUC Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only To the I within 2 To the I 290 License number 58303 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TUNSON NO ZIZEL 1, CHAMES WY 6201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State A SORIGINAL Registrar DETWEET BY DAMASTICS I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 21689 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2008 **Physician** 545 PM William Bowland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Huspital edale Baltimor If Unde Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 XM 2 □ F Months Days Hours Min. July 22,1913 Maryland Director 212-05-6793 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Director Baltimore Parkville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō with U.S.A. items 23a 8830 Walther Blvd. #217 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

Armed Forces?

I XVes 2 \(\) No

If Yes, Give \(\) 942-1946

Year or Dates: 1 □ Never Married 2 □ Married 5-0036 natural", or 1 ☐ Yes 2 X No Specify: þ 3 □ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Steel Company 12 Salesman 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Lillian Evans ္ရ William Α. Bowland Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is I any Injury or other traus 630 East Drive 46201 Lyons Niece Indianapolis, Indiana Cynthia 20b. Place of Disposition (Name of Lincoln Memory Gardens
Lincoln Memory Gardens 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-8-2008 4 □ Donation 5 □ Other (Specify) Entombment Whitestown Indiana 21. Signature Thur a Service Liberisee 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland 21204 Inc. 1050 York Road Low 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed physician and s the burlal-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. been signed by the should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed /24b. Were autopsy findings available prior to completion of cause of death? or Attending Physician: The law 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☑ Yes 2 ☐ No Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? his assisted living 1 Natural 5 Pending investigation Injury He fell in To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☑ No death. 5:00 pM 2 Accident June 29, 2008 apartment 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide assisted 8830 Walther Bentoco Perkvillezzz living regidence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 058646 13x1 monic 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Drive, Bultimolo 9000 Franklin Squase Monici Anna 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Julia Becker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg 101 Hartwood Drive 8. Date of Birth July 7, 1914 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min. 1 □ M 2√ F Mary Tand 93 217-07-2358 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~~ *** any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Director MD Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21532 101 Hartwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Specify: by White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Santignatio Puglisi Samuel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3153 Edgewood Rd., Ellicott City, MD Robert C. Becker-son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/7/08 Timonium, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1858 York Rd., Towson, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHEMIT FAILURE **Physician** CONGESTIME /Medical Due to (or as a consequence of) **Examiner** Carolis voyabally Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has to page 2 s autopsy performed? Yes 2 No After this certificate funeral director, pag 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

12

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

Healton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0 2690-

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2169 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:10p M 2008 I117 v /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard 12530 Triadelphia Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 👽 F 78 272-28-3444 Feb 18 Director 1930 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It or Mexical Examiner must be rediffed at once. MD Ellicott City Howard 1 ∐Yes 2 🔯 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12530 Triadelphia Road 21042 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) judicial system Elementary/Secondary (0-12) College (1-4or 5+) proof reader 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Rundell Leo N. Barry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12520 Triadelphia Rd., Ellicott City, MD 21042 Debbie Hasty (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Sykesville, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-7-08 All County Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Pargraph Herbert P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 🗌 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy perform certificate 1 □Yes 2X No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes ⊅ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 💢 Natural 1 🗆 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier

State

31. Date filed (Month, Day,

gral Bell lane

30. Hame and address of person who completed cause of death (Item 23a) (Type,

Registrar's Signature

			For State Registrar	State of Marylan	d / Depa	artment of F	lealth and Death	F	Reg. No.	
П	Physicia	_	Decedent's Name (First, Middle, Last	RAYMOND CI	LAUDE	BROTHER	RS	2. Date of Dea Month JULY	Day Yea	3. Time of Death 8:00 A M
Mark.	/Medio Examin		4a. Facility Name (If not institution, give	street and number)			Location of Deal		4c. County of D	eath
	Funaval		3736 NINER RD. 5. Social Security Number 6. Se	ex 7. Age (In yrs.	last birthday)		If Under 24 Hrs		CARRO	Birthplace (State or Foreign
	Funeral Director			ZM 2□F 59	Vro	Months Days	Hours Min	8/23/1	y, _{Year)} 948 Mi	ARYLAND
	pu >		Usual Residence of Decedent 10a. State 10b. County	100 Ci	ty, Town or Lo	cation				10d. Inside City Limits
	f show	5	MD CARROLL		FINKS					1 □Yes 2NNo
	the h	rect	10e. Street and Number		1 11110	10f. Zip Code			10g. Citizen of What	Country?
	h with	a D	3736 NINER RD.			21048			USA	
	r dear	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (i an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Medical Evain her mast be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1		1 □Yes X□No	Specify:		Specify:	WHITE
21215-0036	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation	orkina	16b. Kind of Busine	ss/industry
121	within 7 ene. than "r	Completed	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retired	a)	,,,,,,,,	CONSTRU	CULON
	filed w Hygie other ti		17. Father's Name (First, Middle, Last)			1176 2		me (First, Middle,	Maiden Surname)	CIION
Maryland	be od od	To Be	ROBER	T CLAUDE BR	OTHER	S	IDA BE	ELLE RU	TH FRIEN	D
lary	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship (7	Type. Print)	19b. Maili	ng Address (Street			er, City or Town, Stat	
	1 and 2 Health em 27 i		FAYE R. LERMAN	- SISTER		AYRIDE		PANEYTOV Date	NN , MD 2	
Baltimore,	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	Removal from State		osition (Name of matory or other pla	i		•	
Ë	- + # = -		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licenses	nee PRO		NCE CEME 2. Name and Addre			GAMBER, FUNERAL	HOME, P.A.
ä	Depar Impor any Ir		> ()//)						MINSTER,	
			23a. Part 1. Ent he disease, or comp shock, or heart failure. List only	olications that caused the deal	th. Do not en					Approximate Interval Between Onset and Death
and a	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Chyonic	Ob:	structi	ve P	ulmos Bease	lery	
	/Medical Examiner			Due to (or as a consec	quence of):		DI	3ease	2	
7	B #	ner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	uence of):					
V	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec	tuence of:					
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687	tificate ig phy as the	ledical		. d		0				
Box	eath certifi attending p for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn		Ectopic pregnan	су		23d. Date of Month	delivery Day Year
O. E	ne dea the at hed fo	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			WOTH	Day
О.	uires that the de signed by the a d be detached f	/ Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	ınderlying cause gi	ven in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
Records,	w requires been sign should be	Completed by	CONGESTIV	E HEAR	TF	AILU	RE	1 🗆 '	Yes 2□No 3□	Probably 4 Unknown
eco	e law requ has been je 2 should	plet	ATRIAL	FIBRIL	LA	TION	/	24a. Was	psy prior	e autopsy findings available to completion of cause of
E B	: The cate h	Com						perfo 1 ☐ Yes	rmed? deat 2 No 1 □	h? Yes 2 No
of Vital	sician certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:		- D - o. Oti	her:	eath (Check only o		
o	ding Physician: The h. After this certificate h. funeral director, page	n: To	1 ☐ Yes 2 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o	INT 3 LL DOA	4 L Nursing		dence 6 ☐Other (how injury occurred	Specity)
ion	ath. r: Aft	atio	Natural 5 ☐ Pending investigation		Injury		Yes 2□No			
Division	or Atte	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, st ify)	reet, factory, office		28f. Location (City or To	Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge, dea	th occurred at the	time, date and pla	ce, and due to the	cause(s) and mann	er as stated.
	n 24 h ne Fur	Medical	(Check only 2 Medical Exam	niner: On the basis of examinand manner stated.	ation and/or i	nvestigation, in my	opinion, death oc	curred at the time,	, date and place, and	due to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	0		29c. Licen	se number	_	29d. Datersigned (A	fonth, Day, Year)
	1		410fect of	x4e0 1	n.D	D^2	503	> 2_	1/3/0	XU08
	4		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type) P D I	Print)	SUITE (DRIVE	Mel	163 MD
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		- 12-23 4	VIIIVL,	, , , , , , ,	
	Regist	rar	JOE 0 1 500	LE SEE SEE L	" All the	The same of the sa				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:18 PM **Physician** 2008 Ihomas /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year)
Aug 25, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 🖁 M 2 🗆 F Months Hours 108-34-2850 63 Director 1944 New York Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County er than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director DE Kent Felton 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 19943 4406 Paradise Alley Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No 1962 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Datest O 2008 1 ☐ Yes 2 🔀 No Specify: Š Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4 or 5+) US Navy Professional Navyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance and Mental H Artleigh E. Conklin Agnes K. Gibb ၉ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any injury or other trauonce. Carol DePew Warren 4406 Paradise Allet Rd. Felton, DE 19943 (Fiance) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 7-8-08 Hillside Cemetery Cartlandt Manor, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility E.O. Curry Funeral Home 313 N. James St. Peekskill, NY 10566 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hypoxemia /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed attending physician and d for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ed by the attend detached for u Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signe page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 □ No 1 Tyes certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 inpatient Other: 4 Nursing Home 5 Residence 3 □ DOA 1 ☐ Yes ည 2 ER/Outpatient 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tyes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ၉ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 6 egistrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 18

Physician /Medical Examiner

Funeral Director

28a-f show

Director

Funeral

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Completed

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CASCIO JUIV6,2008

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant is a must be multiled an any injury or other traumatic event, the Medical Evant is a must be multiled an angue.

Physician /Medical Examine

be executed n and al-trans physician pur The law requires that the death certificate the use as the a signed by t I be detach has e 2 s page Physician: this

Box 68760,

P.O.

Division of Vital Records,

Examiner Physician/Medical Completed by Be Medical Certification: To After the funeral or Attending nours after death.

neral Director: Af

filled in by the fur To the Hospital o within 24 hours af To the Funeral Di completely filled in

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUMPH Cascio 2008 Margaret Anne 1255 ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 16, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days ^{Year)} 1922 1 □ M 2 🕱 F Hours Min. Mary land 86 Feb 219-30-7645 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Baltimore Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 9018 Perring Park Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Bace - American Indian. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anne Dengler Francis Mortimer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md. 21234 Ms. Ruth Holden/ Niece Proctor Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-8-08 Towson, Md. Hilltop Service Co. 4 Donation 5 Dother (Specify) 22 Name and Address of Facility neral Home, 21. Signature of Funeral Service Licensee 1050 York Rd. Towson, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or or implications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 6 Nother (Specify) 105PLCS 1 Inpatient 27. Manner of Death 1 De Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 W. Towsontown Blvd. Towson, Md. 21204 Kendell Faulkner 31. Date filed (Month,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** $p^{\,\mathsf{M}}$ Paul Plaster Costello June 30 2008 8:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☑ M 2 🗆 F Director 227-14-4677 87 29, 1920 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2♥ No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 8718 Tuckerman Lane 20854 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 XYes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. \$ 3 Widowed 4 Divorced Year or Dates: "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within than Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Auto Service Station Owner-Operator permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Charles Haynes Costello Martha Mayhugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 Black Cap Lane, Reston, Virginia 20191-3027

Det Olisposition (Name of Disposition (Name D. Earl Brown, Jr./ Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park July 5,2008Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licenses M01532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hip Fracture

Due to (or as a consequence of): Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Fall Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No signed by the a d be detached f P.O. q [Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrilation, coronary artery disease, dementia, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an hypertension has autopsy certificate 1 ∐Yes 2 No Division of Vital e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifical letely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ٥ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ZYes 2 □ No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 X No June 9, 2008 2 X Accident 1600 Fall 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 5721 Grosvenor Lane Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Nursing Home Maryland 20814 Bethesda, 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D. 17656 July 1, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tipaporn Woodward, M.D. 5530 Wisconsin Avenue #550, Bethesda, Maryland 20815

State Registrar

31. Date filed (Month, Day, Year)

JUL

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 881 7-22-08 vt. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 1:070m Donald Ralph DeMas. Sr. 07 04 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospita
5. Social Security Number | 6. Sex Baltimore Roseda Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, ate of Birth Jonth, Day, Year) **Funeral** Days Hours 1 XM 2□ F 70 11/14/1937 Director Pennsylvania 163-30-9895 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 XNo Director Middle River Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12500 Eastern Avenue 21220 S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XX Yes 2 No
If Yes, Give 1954
Year or Dates: 1977 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Owner / Operator Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Taglieber ဂ္ James DeMas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DeMas (Wife) 12500 Eastern Avenue Middle River, Maryland 21220 Dinah Sue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition $7/\bar{5}$ 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis 18 hrs Severe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a the burial-1 Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) P.0. icate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No Obstruction 3 ☐ Probably 4 ☐ Unknown 1 Tes Recent Small Bowe Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an LAP, Lung Cancer autopsy 1 ☐ Yes 2 ☑ No this certificate Division of Vital 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After to completely filled in by the funera 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

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Donald

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State Registrar (Check only one)

and title of certific

Dr. Martin Sheridan 31. Date filed (Month, Day, Year)

rendar 1

32. Registrar's Signature

30. Name and address of p so who completed cause of death (Item 23a) (Type, Print)

2008 7 0

29b. Signat

DHMH 17 Rev 1/2001

29c. License number

D21846

9000 Franklin Square Drive, Baltimore MD, 21237

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert Lionel Ditch 2008 iTUI 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year)
Jan. 7,1934 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday)
74 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 215-30-3164 Months Hours Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 Yes 2 □ No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1820 Spence St. Apt. 202 21230 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Never Married 2☐ Married 1 □Yes 2. No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Proctor Silex Warehouse Man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth F. Ditch Helen Muffley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Gagne- sister 2201 B Hammond Ferry Rd. Baltimore Md., 21227 20b. Place of Disposition (Name of Warnetery, Cramator of pther place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-3 2008 Odenton, Maryland Crematory 2. Signature of Funeral Service Lice AMBROSE FUNERAL HOME, Inc. 1328 Sulphur Spring Rd act \$ 101450 Arbutus, Maryland 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) ACINETOBACTER BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No EGMONDUS PANCREATITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760.

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after co....

To the Funeral Director: Aft

To the Funeral Director: Aft

Physician

/Medical

Examiner

Funeral

Director

if than "natural", or items 23a or 28a-f show

hours after

permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Its Mer

Physician

/Medical Examiner

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physician

Saltimore, Maryland 21215-0036

Director

by Funeral

Completed

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Examiner

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Certification: To

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29c. License number P20656. 29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 S Caton AVE. Paltimore, MD LISBETH LLOVET.

State Registrar and manner stated.

			1 - State Registrar		Cei	rtificate of Dea	ath	/giene Reg. No.	
			Decedent's Name (First, Middle, Last))			2. Date of D		3. Time of Death
	Physici		CLINTON	D DE	WITT		Month T 1	Day Yea	A.A
	/Medic		4a. Facility Name (If not institution, give		00 1 1 1	4b. City, Town, or Local	July	3 2008 4c. County of De	7:00a ^M
	Examin	er		street and number)		Eldersbu		Carrol1	
			1412 Becket Road	7 400 (/	n yrs. last birthday)				
	Funeral Director		22, 30 , 20 ,	M 2□F 60	Yrs. last birthoay)	Months Days Hou		nn ay, Year) 2 1947	Sirthplace (State or Foreign Country) Ohio
	pur *		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation			10d. Inside City Limits
	a-f sho	ctor	MD Carroll		Eldersbu				1 ☐ Yes 2 ☐ No
	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, Ite Macical Examiner must be notified a	by Funeral Director	10e. Street and Number 1412 Becket Road	I		10f. Zip Code 21784		10g. Citizen of What USA	Country?
	dea ans	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hispania	c Origin? (Specify Yes or Nixican, Puerto Rican, etc.)	0- 14. Race - A	merican Indian,
920	urs after al', or Ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Date:		_	ecity:	Black, W Specify: W	
9	2 ho	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupation		16b. Kind of Busines	ss/Industry
21215-0036	within 7 ane. than "n	Completed	(Specify only highest grad	College (1-4or 5+)	life. I	kind of work done during DO NOT use retired) CPA	most of working	finance	
2	Hygie Ther Int, II		17. Father's Name (First, Middle, Last)				Nother's Name (First, Middle	Maiden Sumame)	
Maryland	2 should be filed withi and Mental Hygiene. Is marked other than aumatic event, Ite M	To Be	Wallace deWitt, J	Jr.			Jean Evelyn (
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Macical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty Mary Doyle (execut				Eldersburg,		o, Zip Code)
യ	Pages 1 a ent of He nt: If item ry or oth	ľ	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		sition (Name of natory or other place) Cemetery	7-9-08	20c. Location - City Glenwood,	
Balti	permit. Pages Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Licens Duay Dougly	99	22	. Name and Address of F	Facility Haight Fur Sykesville,		& Chapel
			23a. Part1. Enter the disease, or compl						Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.					Interval Between Onset and Death
	nysician		disease or condition resulting in death)	MALI	GNANT	MECANOM	A METASTI	ADC	6 yrs.
	/Medical Examiner		rosulting in double)	Due to (or as a co	onsequence of):		20		- 1
			Sequentially list conditions,	o					
	7	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):				
	tificate be executed g physician and as the burial-transit	ш	that initiated events resulting in death) Last	s					
0,	e ex		resulting in death, cast	Due to (or as a co	onsequence of):				
68760,	ate b hysic he b	edicai		đ					
9	rtificate ng phys		IE EEMALE:			_	37.0		
.О. Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of o Month	deliv <i>er</i> y Day Year
Records, P	signed b	by	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the ur	nderlying cause given in P	Part I. 23e. Did	tobacco use contribute	to the cause of death?
Ö	ng la						1 🗆	Yes 2 ZINO 3	Probably 4 Unknown
	eh of	etec					2010000		Probably 4 Dunknown
		Completed					24a. Was	s an 24b. Were prior to death	Probably 4 Unknown autopsy findings available o completion of cause of
		3e Completed	25. Was case referred to medical			26. P	24a. Was auto perf	s an 24b. Were prior to death 22 No 1 Y	Probably 4 Unknown autopsy findings available ocmpletion of cause of
Vital		o Be	examiner?	fospital: 1 ☐ Inpatient	2 BR/Outpatien	Other	24a. Wa auto peri 1 Yes	s an 24b. Were prior to death 22 No 1 Y	Probably 4 Unknown autopsy findings available o completion of cause of ? es 2 No
of Vital	Physician: this certifica ral director, p	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	28b. Time of	Other	24a. Was auto perful Types 1 Yes Place of Death (Check only Nursing Home 5 Res 28d. Describe	s an psy prior to death 1 Y one)	Probably 4 Unknown autopsy findings available o completion of cause of ? es 2 No
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State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:47AM /Medical acility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner +saltimore Security Number If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, 7. Age (In yrs. last birthdav) 9. Birthplace **Funeral** Months Days 1**X** M 2□ F 1 (X Director Usual Residence of Decedent 10d. Inside City Limits State 10b. County 10c. City, Town or Location Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extrained mass be recitled at 1XYes 2∐No HMOVE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe usa elsea Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation usiness/Industry 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Give kind of work done during most of working life. DO NOT use retired) Steel Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Overlang Jon Baltimore, 20b. Place of Disposition (Na cemetery, crematory pr 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility laug 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Sva disease or condition resulting in death) /Medical Due to (or as a consequence Examiner neumoni monetts Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed use as the burial-transi Coronor and Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. the a 1 ☐ Yes 2 ☐ No detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed' 2 No 2 🗆 No 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₽ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 🗆 No To the Funeral Director: completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) CMP 00053150 JULY 2nd 2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 9650 fuple Shelwamale 31. Date filed (Month, Day, Registrar's Signature Year) State Registrar Good !

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APRIL TITHE 200 c 22 per FH C81 777 (8 LS State of Maryland's Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 4:30PM acos 29 Dupree Julia /Medical Town, or Location of Death 4a. Facility Name (If not institution, live street and numbe 4c. County of Death Examiner If Under 24 Hrs. Dryland 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Min. Hours 1 ☐ M 2 🔀 F 251-18-0176 Director 6-16-1919 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Bultimore 1 Yes 2 □ No Funeral Director MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 U.S.A 1000 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Black Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 Is marked ot any Injury or other traumatic ever ှင Johnny sorce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherin Mc Ginnis Baltimor 5009 Goodnow Rd Apt F WD Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury or once. Zedar Hill Cemetery 16 7-5-08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Tri-State Funeral Service 21. Signature of Funeral Service Licensee lta W NACKIN 814 Upshur St. N.W. Washington, D.C. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? Month 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Munknown 1 TYes been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical соmpletely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOLOMON 31. Date filed (Month, Day; Year) 2. Registrar's Signature State Registrar

			For State	State	of Maryla	-	artment of H rtificate of I			giene Reg. No. 20	១១	21701
			Registrar 1. Decedent's Name (First, Middle,	(ast)		001	timouto or i		2. Date of Dea		00	3. Time of Death
	Physici			,					Month	Day	Year	
	/Medic		Kathryn Marie Dy 4a. Facility Name (If not institution,		umber)		4h City Town or	Location of Death	June 27	7, 2008 4c. County of	f Death	9:00 P M
)	Examin	ier	Renaissance Gard		ulliber)							
				S. Sex	7. Age (In v	rs. last birthday)	Silve If Under 1 Year	r Spring If Under 24 Hrs.	8. Date of Birt	Montgo		ace (State or Foreign
	Funeral Director		218-01-8428	1 ☐ M 2 🛣 F	8		Months Days	Hours Min.	June I	Year) 1920	Count	yland
4 24	4 1		Usual Residence of Decedent		1		L			, ->) Talla
	land ow		10a. State 10b. County		10c.	City, Town or Lo	cation				10	d. Inside City Limits
	Man, fsh	to	Maryland Montgo	mery	F	ockvill	e					1 X Yes 2 □ No
	28a noti	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Count	try?
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	ms 2	Funeral	11. Marital Status	12 Was De	cedent Ever in	n U.S. 13. 1	Was Decedent of H If Yes, specify Cuba		ecify Yes or No-		- America	an Indian,
0	hours after death with the Maryland tural", or Items 23a or 28a-f show at Examiner must be notifiled at		1 Never Married 2 Marrie	d 1 ☐ Yes	orces? 2 X No		n Yes, speciny Cuba 1 □ Yes 2X No		Hican, etc.)		, White, e	
5-0036	al", c	by	3 X Widowed 4 ☐ Divorced	If Yes, G Year or			ILIYes ZAINO	Specify:		Specify:	Whi	ce
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Z	within 72 ene. than "nai he Medica	ğ	Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done on NOT use retired	i)	,9			
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land	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, L.	-				18. Mother's Name			?)	
<u> </u>	Meni Meni arked	၉	J. Edward Derenb	erger				Margare	et Kaufm	nann		
Mar	iges 1 and 2 should be filed vorted Health and Mental Hygies If Item 27 Is marked other tortent traumatic event, the		19a. Informant's Name/Relationshi			1	ng Address (Street					,
	1 and 2 Health em 27	. 18	Kathryn C. Del-G	ranado/I	0	l l	4 Sawdust					
altimore,	jes 1 a of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 DRemoval from	n State M.	b. Place of Dispo cemetery, crei	sition (Name of matory or other place	ce)	Date	20c. Location - 0	City or To	wn, State
Ē	permit. Pages Department of I Important: If Ite any injury or or		4 □ Donation 5 □ Other (Spe		C				, 2008	Bethesda	a,_MD) ,
ä	ppartition in the state of the		21. Signature.of Funeral Service L	censee		R	2. Name and Addres	ss of Facility ROD	ert A.) West M	Control	Fun	eral Home/
מ	80 = # 9		10) RS	01	MO	1346 R	ockville,	MD 20850)	ionegome.	. 9 11 0	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that nly one cause on	caused the d each line.	eath. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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	Examiner		On the state of th	, Mit	ral Re	gurgita	tion				1	
	T =	ne	Sequentially list conditions, if any, leading to innectate cause. Enter Underlying Cause (Disease or injury that initiated events	Cue to	o (or as a cons	sequence of):						
8.	rans	Examine	Cause (Disease or injury that initiated events	c								
Š	be executed ician and burial-transit	m	resulting in death) Last	Due to	o (or as a cons	sequence of):						
8/60	ficate be executed physician and s the burial-transit	dical	'	d								
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X Q Q	death certifi e attending p id for use as	an/	23b. Was decedent pregnant in the past 12 months?		utcome pf pre birth 2 P	etal death 3	∃Ectopic pregnancy	/		23d. Date Mon		ry Day Year
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ī.	at th	Physician/Me	9 Unknown						00- 5:44			
'n	w requires that the death certific been signed by the attending I should be detached for use as	by	Part II. Other significant condition	is contributing to	death but not	resulting in the u	ndenying cause give	en in Part I.		Y		e cause of death?
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Hecords	law as be	Completed							24a. Was	osv p	ere autor	psy findings available npletion of cause of
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0	Physiclan: r this certific ral director,	၉	1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing Ho	ome 5 Resid	dence 6 □Othe	r (Specify	/)
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0	endi sath. or: A he fu	atic	2 ☐ Accident investiga				M 1 🗆	Yes 2 □ No				
UIVISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ZOU. Flat	ce of injury - A ding, etc. (Sp	t home, farm, str ec <i>ify)</i>	reet, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rura	l Route Number,
2	ital or rs aft	Ç		I								<u> </u>
	To the Hospital or Attending Physician: Within 24 hours after death To the Funeral Director After this certific completely filled in by the funeral director,	edical	(Check only 2 ☐ Medical E				h occurred at the tir vestigation, in my o					
	the hin 24	ledi	one)		nner stated.							
	7 with 1 0 00 00 00 00 00 00 00 00 00 00 00 00 0	Σ	29b. Signature and title of certifie	1 A	11116	/ .	29c. Licens D236		1	29d. Date signed		
			*	100 1	With	1		サ ブ		June 30,	Z00	
	5		30. Name and address of person w	No completed car	use of death (tem 23a) (Type,	Print)		MD 000	0.4		
			John Stuckey, M	ח. אווס יים.	Grace	ттета ко	i., Silve	r Spring,	MD 209	U4		
	Sta Registr		31. Date filed (Month, Day Year)	7 2008 32.	Hogistran's Si	gnature	TOBALL!					
	negisti	uI.	JUL									

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Certificate of Death Reg. No.2 0 0 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Duckett Valerie Diane 06/22/2008 2:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Medical Center Cheverly 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year! Days 1 □ M 2 🔀 F 07/28/1957 Washington, DC Director 50 579-78-9539 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 ☐ No Director MD P.G. Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 U.S.A. 1117 Chapelwood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 🔀 No Specify Specify: þ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cavanaugh Doby Docha Marie James Wesley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1225 Palomar Pl.#71 Vista,CA 92084 Ernest M. Hawkins Jr. / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale, MD 4 Donation 5 Other (Specify) 07/03/08 Riverdale Crem. 22. Name and Address of Facility Ronald Taylor II Funeral Am. 21. Signature of Juneral Service Licenses 108 W.North Ave.Baltimore,MD 21201 + analex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 No been signed by the should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 XNo After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death | Director: / d in by the f 2 Acciden 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) ח 24 hours the Funeral Dirr יויי filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catavenis M.D. 3001 James Hospital Dr. Cheverly, MD 20785 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar JUL 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1 tem 10c per fh 2881 7-9-08 vt.
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 GUSSIE MAE DENT 0 /Medical 4a. Facility Name (If not institution, give street and number) 5601400 (c. 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Sementan Hospital Roven Bld Baltimore Baltimore 8. Date of Birth (Month, Day, Year) (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Country)
GA. 1 M 2 Director 252 48 8451 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. **AUGUSTA** N/A -GEORGIA 1X Yes 2 □ No GA. **Funeral Director** 10f. Zip Code 30901 10g. Citizen of What Country? 10e. Street and Number 1457 MILL ST. USA 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 😥 No Specify: Specify: BLK Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12TH DOMESTIC PRIVATE HOMES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES R. WILLIAMS INEZ AVERY မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA COSBY (daughter) 1209 WALTERS AVE. BALTO, MD. 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Permoval from Sta July 10,2008 AUGUSTA,GA. CEDAR GROVE CEM nation 5 ☐ Other (Specify) ature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ctage Overion care nome 4 Physician disease or condition resulting in death) /Medical Due to (s a consequence of): Bleeding Examiner treeto Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and the burlat-trans Due to (or as a consequence of): Physician/Medical as attending p for use as nse IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnapt 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9□Unknown 9 Unknown Part II; Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Hypertension 2 No 3 Probably 4 Hiknown 1 Yes diverticulitis his tor 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performe has 21110 certificate 1□ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Medical Certification: To Be examinera 1 des 2 No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this (After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident death. the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours after 29a, Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signa edical Resident RES 000 Good Saman ne and address of person who completed cause of death (Item 23a) (Type, Print) BID, BOHIMORE 1ch 31. Date filed (Month, Day, Year) . Registrar's Signature State JUL 0 7 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For amend #5 Per FH G881 Maryland / Department of Health and Mental Hygien 008

Certificate of Death

Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2:52 AM **Physician** 2008 EHa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2ROLLHOSPICE DOVE HOUSE WEST MINSTER
If Under 1 Year | If Under 24 Hrs. | 8. [CARROLL 9. Birthplace (State or Foreign Country)

MARYLAND 8. Date of Birth (Month, Day, Year) JUNE 22 1932 245-28-5244 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Days Hours Yrs. 215 28 Director Usual Residence of Decadent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "neturel", or Items 23e or 28e-f ehow 10b. County 10c. City, Town or Location 10a. State treumatic event, the Medical Examinar must be notified at 1 Yes 2 No BALTIMORE BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 USA 81 VISTA Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) CAREFIRST College (1-4or 5+) Elementary/Secondary (0-12) CREDENTIAL SPECIALIST 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be H. HEALEY, SR OLIVE WALBERT WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3128 CARROLLTON ROAD FINKSBURG-MO permit. Pages 1 and 2. Department of Health a Important; If item 27 is eny injury or other treu once. PORTER DAUGHTER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 9/2008 ORRAINE Park Com WOODLAWN, MO 22. Name and Address of Facility J N Zum Brun FH & mon Ce 21. Signature of Funeral Service Licensee SYKESVILLE ROCKY ELDERS BURG-MYD 21784 Rart1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Retro Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use copyribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 1 No 1 ☐ Yes 2 1 Yes 25. Was case referred to edical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence P 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death e Hospitel or Attending Pl 24 hours after death. e Funeret Director; Atter ti Certification: 1 Natural 2 Accident 5 Pending investigation 2 🗌 No 1 🗌 Yes e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be determin 4 Homicide within 24 hours a To the Funeret C Certifying Physics of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) any manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier erson who completed cause of death (Item 23a) (Type, Print) 0 Name and addr uto (31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUL 0 7 2008

			State of Maryland / State of Maryland / State of Maryland /		rtment of Heal tificate of Dea		ental Hygie Reg	ne . No. 20	08	21705
Г	Physici	an	1. Decedent's Name (First, Middle, Last) Arthur J. Fassio, Sr	-		2	July 3,	2008	Year	3. Time of Death 12:47 a M
	/Medio		4a. Facility Name (If not institution, give street and number)	•	4b. City, Town, or Local		,	4c. County	of Death	re
*	Funeral		1910 Haverhill Road 5. Social Security Number 217-16-5418 ★★★ 2□ F 84		Baltimc If Under 1 Year If	nder 24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent	Yrs.			1/20/192	T		
	Marylan -f show	tor	MD Baltimore 10c. City, To Balti		eation				1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the	Il Director	10e. Street and Number 1910 Haverhill Road		10f. Zip Code 21 234			g. Citizen of V SA	Vhat Cour	ntry?
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Medical Examination in an analysis of other traumatic event, if a Medical Examination in an analysis of other real page.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3★□ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. ∀es 2 □ No □ Ves 2 □ No □ Ves 2 □ No □ Ves Year or Dates:	If	Vas Decedent of Hispani Yes, specify Cuban, Me	ic Origin? (Specexican, Puerto Recify:	sify Yes or No- ican, etc.)		k, White,	can Indian, etc.
21215-0036	vithin 72 hou ane. t han "natura u Medical E	Completed		6a. Deced (Give K life. D	ient's Usual Occupation kind of work done during OO NOT use retired) BMAN	most of working	7	16b. Kind of Business/Industry Pharmaceutical		
land 2	ld be filed v ental Hygie ked other I Ic event, II	To Be Co	17. Father's Name (First, Middle, Last) Joseph Fassio			Mother's Name	(First, Middle, Ma Profili	aiden Surnan	ne)	
Baltimore, Maryland	und 2 shou alth and M 27 Is mar er traumat		19a. Informant's Name/Relationship (Type. Print) Marion Hilton / Daughter	19b. Mailin 3709	g Address (Street and N Putty Hill	lumber or Rural Ave. No	Route Number, C ottingha	City or Town, m,MD	State, Zij 21 23	o Code) G
more	Pages 1 ament of He ant: If item ury or oth		1 Transist 2 Comption 2 Demoval from State	etery, crem Wood	sition (Name of natory or other place) Cemetery	7/7/20	008 B		re,	Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	22	Name and Address of F					ome, inc.
68760,	ficate be executed Physician and Physician	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent or complication of the conditions of the cond	ce of):	Jen J Ans	Dor 3m	Du	seu	7	Approximate Interval Between Onset and Death
O. Box	at the death certific by the attending p tached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown			ite of deliv	very Day Year			
rds, P.	quires that en signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause given in I	Part I.		acco use con		the cause of death?
I Reco	. The law requir cate has been s page 2 should	Completed					24a. Was an autopsy performe	ed?	Were aut prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 2 No
Vita	ysician: The is certificate hidrector, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	3/Outpatien	Other		(Check only one)		ner (Spec	ifv)
Division of Vital Records,	Attending Ph or death. ector: After th by the funeral	Certification: T		Bb. Time of Injury	28c. Injury at Work? M 1 Yes	2 □ No	8d. Describe how	v injury occur	red	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.		vestigation, in my opinio	n, death occurre	ed at the time, da	te and place,	and due	to the cause(s)
	North Com	Σ	29b. Signature and title of certifier Menh Monn M	>	29c. License num	184		d. Date signe	-	
	10x1		30. Name and address of person who completed cause of death (Item 2:	7	Print)			T	-our	Surmd
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	bore						01209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** toreman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death mar If Under 24 Hrs. 8. Date of Birth (Month, Day If Under 1 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days -28-088 Year) 238 Director Carole Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f sh notified 1 Kes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

The marked other than "natural", or Items 23a or any Injury or other traumatte event, the Medical Examiner must be a Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 27X No 1 🗌 Yes þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b-Kind of Business/Industry Delto Elementary/Secondary (0-12) 65 no Santation e 18. Mother's Name (First, Middle, Maiden Surname, Be 17. Father's Name (First, Middle, Last) Stel O 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eirelenotx -neice 7021 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sana ire of Funeral Service Licensee Wallace M sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death shoot, rhea ill Immediate Cause (Final disease or condition resulting in death) Physician 6 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) as the burial-trans requires that the death certificate be exe Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year ned by the a 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 13:51 July Ann K. Flynn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year ge (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Months Days Hours Min. 1 □ M 2 🕱 F Yrs. 1928 August 31, New York 79 Director 578-34-6561 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County s 23a or 28a-f show ust be notified at 1 ☐Yes 21 No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20854 United States Funeral 11608 Georgetowne Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation th and Mental Hygiene.

7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own_home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Mae McSherry James T. McCarthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: if item 27 is any injury or other trau 17816 Cliffbourne Lane, Derwood, Maryland 20855
pe of Disposition (Name of Date 20c. Location - City or Town, State Karen Flynn-Huff/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Ind July 6, 2008 Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 M01532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 🖾 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Nanpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Chini July 2, 2008 FC0796269 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 20 Medical Center Drive, Rockville, Maryland 20850 Payam Chini, M.D. 9901 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL.

			For State Registrar	State of Maryland	-	tment of H ificate of E		lental Hygie Reg.	ne no. 2008	3 21708
	Physicia	an	1. Decedent's Name (First, Middle, Last	· -				2. Date of Death	Day Year	3. Time of Death
	/Medic		#A. Facility Name (If not institution, give	ferguson street and number)	4	b. City, Town, or	Location of Death	/ 3	200 4c. County of De	ith
گر سد.				pice		Towso m	If Under 24 Hrs.	O. D. A. of Distle	Balta	
	Funeral Director		5. Social Security Number 6. 9	7. Age (In yrs. las		Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye.	1916 0	rthplace (State or Foreign Quntry)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	tion		-		10d. Inside City Limits
	a-fsho	ctor	hed N/A	Ba	1timo	re				1 ₩6s 2 No
	vith the	Director	10e. Street and Number	1		10f. Zip Code		10g.	Citizen of What C	
	ns 232	Funeral	1541 Winde in	12. Was Decedent Ever in U.S.	13. Wa	2/ s Decedent of His	Spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,
980	ours after or all, or item	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		′es, <i>s</i> pecify Cubar ∃Ye <i>s</i> 2 ∑ No	Specify:	Rican, etc.)	Black, Wh	
215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Endical Exa, drac must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give kii	nt's Usual Occupa nd of work done do NOT use retired)	uring most of worki		. Kind of Busines	s/Industry
d 21	should be filed withir nd Mental Hygiene. marked other than matic event, II. II.	Col	17, Father's Name (First, Middle, Last)			199ªY	18. Mother's Name	(First, Middle, Maid	STeden Surname)	
/lan	ev d	To Be	Alexander	Ferguson			Mitt	Farqui	OM	
=	12s hat 7 is frau	0 4	19a. Inform nt's Name/Relationship (7)	ype. Print)	19b. Mailing	Address (Street a	and Number or Rura	al Route N ber, Ci	ity or Town, State	, ,
	tem 2		20a. Method of Disposition	uson Soi.	ce of Disposit	ion (Name of tory or other place	Haven	Lane 200	tigh care Location - City of	M 20777 r Town, State
	Pages ment of ant: If its ury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		ork Cem	7-9-	2008 7	Balto,	hd.
Balt	permit. Pages Department of Important: If i any injury or once.	,	21. Signature of Funeral Service Licens	Dundan	200	Name and Addres	s of Poility	Rolling	Jul Ser	hd. i.c. P.A. 1217 Approximate
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications the caused the death.	Do not enter	the mode of dying	g, such as cardiac	or respiratory arrest,	1700	Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	y A	RTER	4 0152	ASE		HEARS
	Examiner		Cognosticily list conditions	h	since oi).					
	sit / ve	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of).					
o,	an and	Examin	that initiated events resulting in death) Last	cDue to (or as a conseque	ence of):					
8760	icate be executed physician and the burial-transit	dical		d						
	death certific e attending p		Zob. Was decedent pregnant	23c. If yes, outcome of pregnand		Ectopic pregnancy			23d. Date of d	elivery
P.O. B	0 0	Physician/M	in the past 12 months? 1 ☐Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown		Other (specify)			Month	Day Year
3, 1	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions co	entributing to death but not result	ting in the und	erlying cause give	n in Part I.			to the cause of death? Probably 4 1 Unknown
Records,	w requi	Completed	PROSTATE I	PARTER				24a. Was an		autopsy findings available
<u>~</u>	The ate h	dmo;	rigornic	MIVECIN				autopsy performed	prior to death	completion of cause of
Vita	Physician: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		2 DOA Othe	**	(Check only one)		
0	Phy r this	n: To	27. Manner of Death	28a, Date of Injury 2	28b. Time of	28c. Injury	at Nursing Ho	me 5 Residence 28d. Describe how i		pecity) HUSPICE
Sion	Attending r death. ector: Afte by the fune	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	Injury		/es 2□No			
Division of Vital	l or Atl after d Direct d in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	t, factory, office		28f. Location (Stree City or Town, S	t and Number or tate)	Rural Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical C	29a. Certifier (Check only one) 1 Certifying Phy C Medical Exam	/sician: To the best of my know iner: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the time stigation, in my or	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	To th withir To th сопр	Me	29b. Signature and title of certifier	20		29c. License	1 - 0 -		Date signed (Mo	
			30. Name and address of person who d	ormoleted squae of death (the	23a) /Tuna D		4395		Tury 3.	2008
	10		DANIEUE DOBERM	HN, MO 6565	N MI	APLES ST	, 8417 .	209 BA	TIMORE.	MO 21204
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signatu	ire dead	1,				
			35L 3 1 1000	Janes 10.	1900					

A. Getz

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Union Memorial Hospital 8. Date of Birth
9/24/1954 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 □ X F Marviand 212-52-2554 53 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD Sparks Baltimore 1 ☐ Yes 2 ☑ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or items if Items 23a or any injury or other traumatic event, the Medical Examination is the response. 21152 2009 Stringtown Road U₅A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: ٥ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nun Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara E. Ensor E. Allan Zimmerman, Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Stringtown Road Sparks, MD 21152 19a. Informant's Name/Relationship (Type. Print) Robert W. Getz, Jr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp. 20c. Location - City or Town, State 20a Method of Disposition 7/8/2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21204 21. Signature of Funeral Service 22. Name and Address of Facility Towson. Inc. 1050 York Road Ruck Towson Funeral Home, 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** unknown Colon concer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner farlin unknun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other; 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 PAKSME, MO 3,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union memorial hospital ZAHRA BARBAL, MD 31. Date filed (Month, Day, Year) State 0 7 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

2008

6 200 AM

2. Date of Death

July

Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:00 a M Ju₁v 2008 Robert E. Gorman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery

9. Birthplace (State or Foreign Country) Montgomery Hospice Casey House 5. Social Security Number 7 6. Sex 7 7. Age (In yrs If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Hours Days Min. 1⊠M 2□ F Yrs. 1923 Pennsylvania November 5. Director 172-16-9408 Usual Residence of Decedent ath and Mental Hygiene.
27 Is marked other than "natural" or "traumatic event see." 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 反 No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 United States Funeral 719 Kent Oaks Mews 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Engineer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If Item 27 Is marked 1 any injury or other traumatic ev once. မ Elmer Clayton Gorman illian K. Kauffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 719 Kent Oaks Mews, Gaithersburg, Maryland 20878
ace of Disposition (Name of Date 20c. Location - City or Town, State <u>Bernadette Yingling Gorman/Wife</u> 20b. Place of Disposition (Name of St. Joseph Catholic 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) July 10, 2008 Taneytown, Maryland Church Cemetery 21. Signature of Funeral Service Licer Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 M01532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prostate Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ∐Yes 2 X No or Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify)Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 **☐***No 1 ☐ Yes this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 XNatura 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 5, 2008 D0064615

1541

State Registrar Drive, Rockville, Maryland 20850

1355 Piccard

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gewevieve Wroblewski

31. Date filed (Month, Day,

M D 1355 L 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GUSTIN HOMAS CLAVE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIN CENTER If Under 24 Hrs. 8. Date VCATHWOS, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7, Age (In yrs. last birthday Months Days 1**∑**M 2□F unk 51 Apr 212-52-4071 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Baltimore Randallstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10518 Marriottsville Road 21133 USA unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. unk 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Northwest Hospital 5401 Old Court Road Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Prograt Privile Licenses

Ronald S Ward 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pat1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): GANGRENE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown LEFT LEG! STATUS DEST AMPUTATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ENDSTACE RENAL DISCASE 26. Place of Death (Check only one) 1 ☐Yes 2 1 Ho 25. Was case referred to medical examinar?
1 ☐ res 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

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Director

Funeral

Be

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Director

show

Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Macical Experience must be recified at

"natural", or

is marked other than

should be fund Mental

s 1 and 2 si of Health an Item 27 is 1

permit. Pages 1
Department of II
Important: If Ite
any injury or ot

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

pe

as

burial-transi and physician the use for signed by the a this certificate has been funeral death. filled in by the within 24 hours after death To the Funeral Director:

Hospital or Attending Physician: Medical State Registrar

Exami Physician/Medical Be ၉ 27. Manner of Death Certification: 29a. Certifier

> 30. Name and address of person who completed cause of death/(Item 23a) (Type, Print) DRIANDO

28a. Date of Injury (Month, Day, Year)

UNKNOWN

28c. Injury at Work?

1 ☐ Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office
determined

28f. Location (Street and Number or Rural Route Number,
City or Town, State) (5520 MARKICTS VILLE Rd

28f. Location (Street and Number or Rural Route Number,
City or Town, State) (5520 MARKICTS VILLE Rd

28f. Location (Street and Number or Rural Route Number,
City or Town, State) (5520 MARKICTS VILLE Rd

2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29c. License number

VUNE 24, LEES

NENTHWEST HESPITAL CENTER

28d. Pescribe how injury occurred

tal

31. Date filed (Month, Day, Year) JUL

5 ☐ Pending investigation

1 Natural

2 Accident

29b. Signature and title of certifier

3 ☐ Suicide 4 Homicide

32 Registrar's Signature

1 Impatient 2 ER/Outpatient 3 DOA

28b. Time of

MUNGWAMM

State of Maryland / Department of Health and Mental Hygien 2008 21712

			1 - State Registrar					Cer	tificate	of E	Death			Reg. No	C U (50) box
П			1. Decedent's Name (First, Mic	ddle, Last)								2. Date of De		11/	Year	3. Time of De	ath
	Physici /Medio		Morris Glach	man									Month June	25,	^{''} 200	8	9:07 A	ММ
	Examin		4a. Facility Name (If not institut	tion, give	street and nu	ımber)			4b. City, To	own, or	Location	of Death		40	. County	of Death		
			3701 Interna	tion	al Dri	ve #	646		SIL	ver	Spri	ng]	Mont	gome	ry	
	Funeral		5. Social Security Number	6. Se		7. Age	(In yrs. last b	irthday)	If Under 1 Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th Year	-)	9. Birth	place (State or F	oreign
	Director		081-12-4108	15	ДМ 2□F		87	Yrs.	Months	Days	nours	MIFI.	Dec 22	, 19	20	New		
	D.		Usual Residence of Decedent															
	how		10a. State 10b. Cour	nty			10c. City, Tov										10d. Inside City	
	Ma P	cto	MD Mont	gome	ry		Silve	er Si	pring								1 Tes 2	K NO
	다 다 50 g c 28	Funeral Director	10e. Street and Number			,,			10f. Zip C					10g. C		What Cou	ntry?	
	23a	ie	3701 Internat	iona	.I Driv	re #1	546			209	06				USA	7		
	dea dea	ne	11. Marital Status		12. Was Dec	edent E	ver in U.S.	13. V	Vas Decede Yes, specif	nt of His	spanic Or	igin? (Spen, Puerto	cify Yes or No Rican, etc.)	o-		ce - Ameri	can Indian,	
2	or it	F	1 Never Married 2 ☐ M	1	1 X Yes	2 N	0		□Yes 2		Specify:		,,			φ: whi		
2-0020	ural',	d by	3 Widowed 4 Divord	ed	Year or I	Dates: 1	42-62											
2	within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-f ahow I.a Medical Exacilirar coual be codified at	Completed	15. Deced (Specify only hig	lent's Edu hest grad	ication le completed,)	168	Give	lent's Usual kind of work OO NOT use	done d	ition <i>Juring m</i> os	t of work	in <i>g</i>	16b. k	Kind of B	Business/In	ndustry	
V	vithin han	ם	Elementary/Secondary (0-12	2)	College (1-4or 5	+))							İ
Z	tygie tr.		1.2 17. Father's Name (First, Midd	la Lasti	4			tec	hnicia	an	10 Moth	oda Nome	(First, Middle			onics	S	
yland	be fi	Be												, Maluel	ii Suman	110)		
Ž	ould Mer Marke	ို	Isidor Glach										Mutter					
ō	2 sh and ls m	1	19a. Informant's Name/Relatio		rpe, Print)								al Route Numb					8
a)	and teelth m 27		Bill Lomp/cou	ısin			20h Blass	.1120	0 73rd	l Av	enue	Fore	st Hil	1. N	Y 1	1375	Ctoto	
	i of H If Ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic	on 3 □F	Removal from	State	20b. Place cemete	ery, cren	natory or oth	er place	9)		Date	20c. L	_ocation ·	- City or 1	own, State	
	men men mant: lury		4 Donation 5 ☐ Other			7_		-										
Saltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural; or itema 23e or 28a-1 show any injury or other traumatic evant, the Medical Examinating mail he notified at ance.		21. Signature of Euneral Konal V	S. Licens	Sade,	hire	ctor	St	Name and	Addres	s of Facili	oard	655 W	. Ba	1tim	ore 9	Street	
0	207 2 2 3	7 17	som	//	Xu	LL		Ва	ltimo:	re,	MD	<u> 2120</u>	1			010		100
			23a. Part1. Enter the disease, shock, or heart failure. L	or comp	lications that	caused each lin	the death. Do	not ente									Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		C	nN	UES	TTV	EF	105	ART	FA	ILUX	(=		1	Onset and De	Fin
	/Medical		resulting in death)		aDue to	(or as a	consequence	of):	0 1	10,	1, 1	101	10.				ocy ra	260
	Examiner				h													
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	Due to	(or as a	consequence	of):										
	outed ansil	Examiner	Cause (Disease or injury that initiated events	1	c											1		
Š	exe en ar rial-t		resulting in death) Last		Due to	(or as a	consequence	of):										
00/00	ertificate be executed ding physicien and se as the burial-transit	Medical		·	d													
8	ig ph as th	ed																
X D	h cer endir use		IF FEMALE: 23b. Was decedent pregnant	;	23c. If yes, or		of pregnancy 2 Fetal deat	h 2	Ectopic pre	202024					23d. Da	ate of deliv		
	death e etten ed for u	by Physiclan	in the past 12 months? t ☐ Yes 2 ☐ No		4∐Preg	nant at	time of death		Other (spec						М	onth	Day Ye	ar
5	t the by th	hys	9 Unknown		9□ Unkr	nown												
	s the	y P	Part II. Other significant cond	litions co	ntributing to	leath bu	t not resulting	in the ur	nderlying cau	use give	n in Part	l.	23e. Did	tobacco	use con	tribute to	the cause of dea	ath?
gs,	quire on sig uld b		ADV	01	FO	76	PE	((2 11	IKI	VB		10	Yes 2	2□No	3 🗌 Pro	bably 4 Dun	known
2	s bee	jet											24a. Wa:	an	24b.	Were aut	opsy findings av	vailable
Ē	The law requires thet the death certific sete hes been signed by the ettending p page 2 should be deteched for use as	Completed												ormed?		death?	ompletion of eau	use of
<u> </u>	iician: Th certificete rector, pag	Ö	25. Was case referred to med	ical							26 Place	o of Doot	1 ☐ Yes		0	1 🗆 Yes	2000	
	s cert	ToB	examiner?	-	Hospital:	Inpatie	nt 2 ER/C	utnation	t 3 DOA	Othe			me 5 Thes	-	6 🗆 Ott	har (Spac	(64)	
5	Phy or this		27. Manner of Death	_	28a, Date	of Injur	y 28b.	Time of		c. Injury Work	at		28d. Describe				ny)	
UNISION	th. : Afte	ţ	1 Vatural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(Moi	nth, Day	Year)	Injury	м		(? Yes 2□	No						
2	Attan dea ctor y the	flca	3 ☐ Suicide 6 ☐ Cou	uld not be	28e. Plac	e of Inju	ry - At home, t	farm, stre	eet, factory.	office			28f. Location	(Street a	and Num	ber or Rui	ral Route Numb	er,
\leq	after Dire	Certification:	4 Homicide	BIIIII 160	build	ding, etc	. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				City or To	wn, Sta	te)			
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	a	29a. Certifier 1 Certif	ying Phy	sician: To th	e best c	of my knowledg	ge, death	occurred at	t the tim	e, date a	nd place.	and due to the	cause	s) and m	anner as	stated.	
	24 Full	edicai	(Check only 2 Medic	al Exami	iner: On the I	basis of	examination a	ind/or inv	vestigation, i	in my op	oinion, dea	ath occur	ed at the time	, date ar	nd place,	, and due t	to the cause(s)	
	To th withir ro th comp	₹ E	29b. Signature and title of cert	ifier	1/	7	1 N		296	License	number			29d. D	ate signe	ed (Month	Day, Year)	B
	, ,,,,,,,) / ,	//	X	//	-WIL	7		150	84.	>)]	161	NE	21	1200	3
			30. Name and address of pers	on who o	ompleted car	ISO of de	eath (Item 23a) (Type	Print)		A : O			2) ^		, , , , ,	
			N. GOYACIN	10,	300	11/	MERN	LAT	1070	M	DK,	51	LUEX	Sy	RII	W,	WD	
	Sta	ate	31. Date filed (Menth, Day, Ye	2008	32.	Registra	r's Signature	has	20							2	0406	,
	Registr	rar	OOL .		1	1	~ /	A COLUMN	War.									

4b. City, Town, or Location of Death

3. Time of Death

11:20 A.M

2008

4c. County of Death

6

July

	Physician
	/Medical
	Examiner

Paul F. Harrison, Sr.

4a. Facility Name (If not institution, give street and number)

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

ဂ္

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran signed by the attending be a certificate has been si rector, page 2 should After this within 24 hours after death

To the Funeral Director:
completely filled in by the f

Division or Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner

Medical Certification: To

Ridge O	verlool	k Assisted	l Living		We	stmi	nster				Carı	coll
5. Social Security N	lumber	6. Sex	7. Age (In yrs.	last birthday)			If Under		8. Date of Bi	rth	9. 1	Birthplace (State or Foreign
220-16-0	721	1 X M 2□ F	84	Yrs.	Months	Days	Hours	Min.	March	18.	1924	Country) Maryland
Usual Residence of							1					
10a. State	10b. County		10c. City	, Town or Le	ocation							10d. Inside City Limits
MD	Car	roll		Woodb	ine							1 ∐Yes 2 📉 No
10e. Street and Nu	mber				10f. Zip	p Code				10g. Citi:	zen of What	Country?
7401 Jol	nn Picl	kett Road				21	797			Unit	ed Sta	ates
11. Marital Status		12. Was Dec Armed Fo	edent Ever in U. orces?	S. 13.	Was Dece	dent of H	lispanic Or an, Mexica	rigin? (Sp	ecify Yes or N Rican, etc.)	0-	 Race - A Black, W 	merican Indian, hite, etc.
1 ☐ Never Marr 3 ☐ Widowed		ried 1 ☐ Yes If Yes, Gi	2 X X o ive		1 ☐ Yes		Specify.		. ,		Specify:	White
(Spec	15. Deceder	nt's Education est grade completed)		(Give	edent's Usu kind of wo	ork done	during mos	st of work	king	16b. Ki	nd of Busine	ss/Industry
Elementary/Second 12th	ondary (0-12)	College (1-4or 5+)	_	po not u rmer	ise retire	a) 			Se	lf-em	oloyed
17. Father's Name	(First, Middle,	Last)					18. Moth	er's Nam	e (First, Middle			-
Charle	es Harı	rison					Myr	tle	Belle 1	Linds	ey	
19a. Informant's N	ame/Relations	ship (Type. Print)		19b. Maili	ing Address	s (Street	and Numb	er or Ru	ral Route Num	ber, City o	r Town, Stat	e, Zip Code)
Dorothy		son Wife		740	01 Jol	hn P	<u>icket</u>	t Ro	ad Woo	odbin	e, MD	21797
	☐ Cremation	3 □Removal from	Ctoto C	lace of Disponentery, cre	matory or	other pla	ce)	Tulk	Date 9, 200		cation - City oodbit	or Town, State
4 Donation			, 10						J, 200	γ° "	OOGDI	10, 110
21. Signa are of Fu	Mul	19 Cal	my	Bu	2. Name a Irrie 1212	r-Qu W. O	een F ld Li	uner bert	al Home y Road	e & C Wi	remato nfielo	PA 1, MD 21784
		r complications that of the control one cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause of the caus	caused the deat each line.	h. Do not er	nter the mo	de of dyi	ng, such as	s cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Imminiate Cause disease or condition resulting in death)	(Finat on	_aA		enal	Fail	vne						2 uks
			(or as a conseq	uence of):	L	1						1 . 1
Sequentially list co	enditions,		or as a conseq	uence of):	Truc	NON						6 Man/65
Sequentially list co cause. Enter Unde Cause (Disease or that initiated events	erlying a injury	S										
resulting in death)	Last	Due to	(or as a conseq	uence of):								
		d										
IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, ou	utcome pf pregna birth 2 □ Feta	ancy	□Ectopic p	roanana	.,				23d. Date of	,
in the past 12 1 ☐ Yes 2	⊠ No		nant at time of d		Other (s		у				Month	Day Year
		ions contributing to c	leath but not res	ulting in the o	underlying	cause giv	en in Part	l.	23e. Did	tobacco u	se contribut	e to the cause of death?
		s Diseas			pider	4	_,		1	Yes 2	No 3□	Probably 4 Unknown
Hyper	tens	100							24a. Wa	s an opsy	24b. Were	a autopsy findings available
71									per 1⊟ Yes	formed?	death	to completion of cause of 1? Yes 247 No
OF Man ages refer	read to modice	al.	-				00 Di	- (5	4b. /Ob = -1:1:			

State

Registrar

Babak Imanoel 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

examiner?

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

200 No

5 Pending investigation

6 Could not be determined

218 Washington Heights Med Ctr; Westminster, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

28a. Date of Injury (Month, Day Year)

Other:

1 ☐ Yes 2 ☐ No

廿53939

28c. Injury at Work?

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

4 Nursing Home

5 ☐ Residence 6 ☐ Other (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

3□ DOA

0 7 2008

2 ☐ ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20081 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 9:14 PM M Ruth E. Hess June 13, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 22190 Bull Road Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 81 Jan 25, Director 179-30-0896 1927 Germany Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County *ohe Item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehov other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2√ No MD St. Mary's Director Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22190 Bull Road 20650 USA deeth by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 white Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) accountant financial 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mentai f Health and Menta Item 27 is marked Karl Thomas Pleither 2 Sophia Barbara Hilner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine A. Taylor/daughter 22147 Bretan Wood Court Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = Depertment of important: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Luneral Service State Anatomy Baltimore, MD Name and Address of Facility tate Anatomy Board altimore, MD 2120 655 W. Baltimore Street Baltimore, MD 21201

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the attending | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy partorm 2 No 1 Yes Hospital or Attending Physician: after death.

Director: After this certific
J in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ဥ 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide pelli within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number H0055751 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

40900 Merchants

2. Registrar's Signature

In Leonardtown MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schmidt 20.

7 2008

08-05071 Geo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21715

orge H	olman			or State Of Maryland / Department of Product and Maryland / Department	Reg. No.	3. Time of Death
P	hysicia		Regi 1. D	pecedent's Name (First, Middle,Last)	nte of Death onth Day ne 30, 2008	Year 1957 hrs
edical	Examir	ner	_	George L. Ho1man Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. 0	County of Death
				Laurel		ince George's
Fı	uneral		5. 5	Social Security Number 6. Sex 7. Age (11 yrs. last shalles)		D/YYYY) 9. Birthplace (State or Foreign Country)
Di	rector			218-42-6584	Teb. 23,	1946 Virginia
	ı,			ual Residence of Decedent a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 X No
72	how a	Ļ		MD Howard Jessup	Jana Citia	en of What Country?
darvlan	28a-f s	Director	10	e. Street and Number		
12424	und be more writing a most comment by given. Markel Hygiene. market other than "natural", or items 23a or 28a-f show any te event, the Medical Examiner must be notified at once.		L	Maryland House Correction Road 20794 Maryland House Correction Road 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 14. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 14. Was Decedent of Hispanic Origin? (Specify Decedent Ever in U.S. 14. Was Decedent Origin? (Specify Decedent Ever in U.S. 14. Was Decedent Origin? (Specify Decedent Ever in U.S. 14. Was Decedent Origin? (Specify Decedent Ever in U.S. 14. Was Decedent Origin? (Specify Decedent Ever in U.S. 14. Was Decedent Origin? (Specify Decedent Ever in U.S. 14. Was Decedent Ev		14. Race - American Indian, Black,
2424	tems s	Funeral		Married 2 Married 2 Married 2 Married 2 Married 1 Voc. 2 No.	in, etc.)	White, etc. Specify: Black
fer de	l", or	by Fu		X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: BLACK find of Business/Industry
5 77 hours 2	natura Exami	ed b		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		
36	e. than "	Completed		None		employed
9-0	lygien other the Me	Con	17	7. Father's Name (First, Middle, Last) Marie Glo		Surname)
21215-0036	ental F arked	Be		Willie D. Holman Marie Gregoria Marie Marie Gregoria Marie Marie Gregoria Marie Marie Gregoria Marie M	Route Number, C	ity or Town, State, Zip Code)
	D 773 07 13	ြို	115	Pagetown Road, Fab	or VA 2	22938 Location - City or Town, State
	rages I and 2 sn ment of Health an tant: If item 27 i	ŀ	20	Oa. Method of Disposition 20b. Place of Disposition (Name of Centerally,		
mor	Pages ent of int: If			Metropolitan Crematory Jul.	3,2008 A1	Lexandria, VA
Baltimore,	permit. Pages Department of Important: It			1. Signature of Funeral Service Licensee Lames Mad H. Dillwyn	. VA 239	936
	ysician	_	2	20 Port I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	espiratory arrest, sh	nock, or heart Approximate Interval Between Onset and
	Medical			failure. List only one cause of each mile. failure List only one cause of each mile.	ease	Death
	ıminei	1	C	Due to (or as a consequence of):		
		ā	5 i	Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):		
.4		Evaminer		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
	nd nd ransit			d		
	eath certificate be executed tatending physician and for use as the burial - transit	1 5	Physician/Medical	MUNPENDED AMENDED 23a,27,perME, g882 . 8/8/08 TT	2	3d. Date of delivery
3760	ificate lig physicate by the biase of the bi	JW/		FFEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnance	су	Month Day Year
Box 68760,	th certi	o an ac	Sicia Sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown		
, B	that the dea ted by the a		Ž	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? No 3 Probably 4 Unknown
P.O.	res that signed b	and i	<u>a</u>		1 Yes 2	24b. Were autopsy findings available
rds,	w require	nonia	Completed		autopsy	prior to completion of cause of death?
eco	he law ate has	age 2 s	티		1 Yes 2	No 1 Yes 2 No
<u> </u>	rysician: The	ctor, p	Bec	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing		sidence 6 Other:
Division of Vital Records,	Physic er this	ral dure	라	1 Ves 2 No impaterit 2 Electronic State of Injury 28b. Time of Injury at Work?	28d. Describe how	injury occurred
0 0	nding Pl th.	e fune	틸	1 Natural 5 Pending		Dumi Pouto Number City
/isic	or Attend after death. Director:	in by th	ligal	3 Suicide 6 Could not be 28e. Place of Injury - At Home, lamit, stroot, leading to	28f. Location (Stree or Town, State	et and Number or Rural Route Number, City
Ö	pital o	filled	Certification:	4 Homicide determined (Specify)	due to the cause(s)) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and control by the attending physic			one) and Medical Examiner: On the basis of examination and/or investigation, in thy opinion, death seems a		
	To the within	com	Medical	29b. Signature and title of certifier 29b. Signature and title of certifier	29	9d. Date signed (Month, Day, Year)
				Infort & Buthall, MI)		July 2, 2008
	4			30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	/ID 21201	
<u> </u>	\			21 Date filed (Month Day Year) 3 Registrar's Signature		
	Rec	Sta gist	ate rar	31 Date like 1111 0 7 2008		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:45 PM 2008 /Medical County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ARROW IEW NURSING HOME If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Months Davs 1 M 2 F 38-34-016 113 NC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

nt: If them 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Salisbury MD Wicomico 1 ☐ Yes 2 ▼ No Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21804 1300 Hamilton St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify q 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) food service College (1-4or 5+) cook 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sue Fannie Woods Balford Williams ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1300 Hamilton St., Salisbury, MD 21804 Janis Williams (daughter) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Injury or All County Cremation 7-8-08 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical quence of): Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 ☐ No 3 Probably 4 ☐Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has , page 2 autopsy performed? Yes 2 No 2 No certificate 1□ Yes Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation thin 24 hours arter co.

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 ord

State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Mary		epartme Certifica			and M		jiene leg. No. 2 (008	217	17
Ė			1. Decedent's Name (First, Middle, Last)							Date of Dea Month		Year	3. Time of De	eath
	Physicia /Medic			Bessie C	. Kent	Но]	lmes			6		800	9:15	a ^M
	Examin		4a. Facility Name (If not institution, give s				, Town, or		of Death		4c. Coun	ty of Death		
, e			Harborside N, 5. Social Security Number 6. Sex		n yrs. last birtho		Ltimo er1Year	If Under	24 Hrs. T	8. Date of Birth			place (State or F	Foreian
	Funeral Director			M 2□F	68 Yr	Months		Hours	Min,	(Month, Day 5-17-	; Year)	Coul	N.J	
Ţ	5		Usual Residence of Decedent							J 17	17-10			
relate	show	ř	10a. State 10b. County		Oc. City, Town o							1	0d. Inside City 1√2 Yes 2	
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ŧ,	aor	Ē	10e. Street and Number 800 N. Streepe	er Street		101. 2	ip code	21:	205			S A	iti y :	
da da	ms 2%	Funeral Director		12. Was Decedent Eve		13. Was Dec	edent of Hi			ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ		
و ا	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		if Yes, sp		n, Mexicar Specify:	n, Puerto	Hican, etc.)		ack, White,		
-50036	ural",	d by	3 X Widowed 4 □ Divorced								Spec		Black	
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and,	al Hyg othe	BeC	17. Father's Name (First, Middle, Last)	Unk	7 21	171.001				(First, Middle,	Maiden Surna			
aryland 21213-0036 should be filed within 29 hours efter death with the Manufach	Ments arked atic e	2		Olik				Rac	hel	Miller	•			
0	, co .es .es		19a. Informant's Name/Relationship (Ty)		11	-				I Route Numbe			Code)	
	Healt em 27		Tyrone Jefferso		20b. Place of D	34 Ya		venu		alto,	20c. Location		own. State	
	y or o		1 Burial 2 ☐ Cremation 3 ☐ R	smayal from State	cemetery,	crematory or on Cet	other place	cy :		2008	Lanso			
	Department of Heal Important: If item 2 any Injury or other once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Ir-I Service License	ee l		22. Name a	and Addres	s of Facilit	у Ма	rch Ea	st F/	'H		
ם פֿ	lmpo any l		Brack Miller			110	lΕ.	Nor		venue			MD 212	:02
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the	death. Do not	enter the mo	ode of dyin	g, such as	cardiac o	r respiratory ar	est,		Approximate Interval Betwe	eņ
	nysician		Immediate Cause (Final disease or condition resulting in death)	are	bru V	even	Son.	Ba	in	lant			Onset and De	ath
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ath c	aftending p for use as	ian/	in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 Ectopic		/				ate of deliv Nonth	ery Day Ye	ar
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o, ⊓ es that	signed by the	by P	Part II. Other significant conditions con	tributing to death but no	ot resulting in th	ne underlying	cause give	en in Part I		23e. Did to	bacco use co	ntribute to t	he cause of dea	ath?
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	has be	Completed								24a. Was a	sv /	. Were auto	opsy findings av	ailable use of
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5 4	er this	٦.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpa		28c. Injury Work	4 - Nu		ne 5 ☐ Resid 28d. Describe h			fy)	
	ath. r: After thi e funeral c	atior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Ye	ear) Inju	ry M		? Yes 2 🔲						
Atte	er deg	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm Specify)	, street, facto	ry, office		1	28f. Location (S City or Tow	treet and Nun	nber or Run	al Route Numbe	er,
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the Hospital or Attending Physician: The law requires that the death certificate	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		sician: To the best of mer: On the basis of ex	amination and/									
To the	othe omple	Mec	29b. Signature and title of certifier	and manner stated		2:	9c. License	number		2	29d. Date sign	ned (Month,	Day, Year)	
ř	s F o		> / Lent		MA		D:	3(4	69		18	301	08	
•	0		30. Name and address of person who co	mpleted cause of death	n (Item 23a) (Ty	pe, Print)				, ,	-4	210	201:	
)	l di	SHOALL A. HA	Spul w		IN.	tu	140	V -	22 8	vite -	20 D. L.	3 alm	212
	Stat Registra		31. Date filed (Month, Day, Year)	62. Registrar's	Signature	auth								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 9:52 PM gare Harris 03 2008 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name 👭 not institution, give street and number) Examiner Agnes itospital saltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 3. 5. 1905 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 03 Yrs. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Its Medical Examinar must be a differed 1 Yes 2 □ No Director MDtimore 10g. Citizen of What Country? 10e. Street and Numbe 21216 IJSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working TO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) UNK Elementary/Secondary (0-12) College (1-4or 5+) omestic Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be 199S largare Informant's Name/Belamonship (Type. Print) Grand Grand 19b. Mailing Address (Street and Number of Daughter) 9 Fron Bolt Ct. ural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. tepney atonsuille, and of Health Tatricia 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 0.08 Ridge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Final NEUMONIA 30AYS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner physician and the burial-transit resulting in death) Last Due to (or as a consequence of): pe Physician/Medical signed by the attending p P.O. Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor Month Year 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by FAILURE HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PSYCHOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION s certificate has b lirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ♥ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 20661 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) g_{I} BALTIMORE 21229 900 Caton SAMUEL NORWEL Avenue

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year,

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2008 5:15 P M July Sae Dong Han /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Day, 1 Months Days Hours Min. 1 ☑ M 2 ☐ F Ĩ934 | Director 448-56-9369 73 Nov. Korea Usual Residence of Decedent oarfment of Health and Mental Hygiene.

oortant: If item 27 is marked other than "natural" or home of lines in Income. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 😿 No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20906 3310 N. Leisure World Blvd., #204 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2K No Specify. Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Driver Livery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Soon Hee Kim Kwang Sun Han 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2001 N. 15th St., #605, Arlington, Virginia 22201 Helena Han / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit, Pages Department o Important: If i any Injury or once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 9, 2008 Rockville, Maryland Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. E ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END RENAI STAGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, find the cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 2 🔽 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe лпеод 2 **Д** No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 .Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D.0 H0064588 July 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20903 Ashish Tolia, D.O.,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

07

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 Jüly 4, Virginia Martha Jett 6:50 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mari | 3, | 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 1916 92 577-42-6145 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 → No Director MD Howard Ellicott City 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 21043 5321 East Glen Road United States Funeral 14. Race ~ American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2X No Baltimore, Maryland 21215-0036 Specify: \$ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than any injury or other traumatic event, Ite Many injury or other traumatic event. Elementary/Secondary (0-12) Unknown College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Edgar Preston Florence Falkinburg ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Julia Koch - Daughter 5321 East Glen Road, Ellicott City, MD 21043 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery 7-8-2008 Baltimore, MD 4 Departion Signal re of F 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) LIMPHOCYTIC LEUKEMIA pas **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Day in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) ned by the a Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ LYMPHOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed DEBILIT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PLEE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12008

State Registrar

a m 2000

31. Date filed (Month, Day, Year)

Faulener MD/555 W. Towsentern Blud/Balto MD

DHMH 17 Rev 1/2001

VIRGINIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month <u>10:30P</u>M[™] Raj Kumar Khanna June 30, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign Country) Holy Cross Hospital Silver Spring If Unde 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Months Hours Min. Director 541-52-6993 July 3, 1935 India Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery <u>Silver Spring</u> 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 202 Vierling Drive 20904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Ire Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Harnam Das Khanna Lila Kapoor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ravi Kumar Khanna/ Son 202 Vierling Drive, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July , 2008 4 ☐ Donation 5 ☐ Other (Specify) Crematorium Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Fundal Service License Bethesda-Chevy Chase, Inc M00335 Bethesda, Maryland 20814-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARDIOVASCUL /Medical Due to (or as a consequence of): Examiner SPIRATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed TACKY ARRYTHM and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical ICNANT RURY EFFUSION as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ANENOCARCINOM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HRONIC 1 F1 2 12 No 2 MNo 1 □ Yes 1 🔲 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident after death Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

State Registrar DELROY

31. Date filed (Month, Day,

Year) 32.1

0

MO

32. Registrar's Signature

DHMH 17 Rev 1/2001

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FOREST CLEN RD SS MD

Physic /Med Exam	ica
Funera	
Director	

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

hysici /Medic		Bettye G. Lan	rkin				July 5,	2008 Year	7:00 A M					
xamin		4a. Facility Name (If not institution 1597 Homeland	on, give street and numb Drive, Unit	^{er)} 2D		or Location of Death	1	4c. County of Dea	roll					
ineral ector		5. Social Security Number 219-12-9617	6. Sex 7. 1 □ M 2 ▼ F	Age (In yrs. last birthday, 83 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Y		rthplace (State or Foreign ountry) 1aryland					
at		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town or L	ocation				10d. Inside City Limits					
8a-f sh ptiffied	ctor		arroll		Elder	sburg			1 □Yes 2X No					
23a or 2 ist be no	Funeral Director	10e. Street and Number 1597 Homeland	Drive, Unit	2D	10f. Zip Code 2:	1794		united St						
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fune	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	If Voc Civo	ZX.No	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🗓 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.					
than "natur ne Medical			est grade completed) College (1-4	or 5+) (Give	edent's Usual Occu e kind of work done DO NOT use retire	during most of wor ed)	king 16	Electror	·					
other /ent, th		17. Father's Name (First, Middle	e, Last)	DACC	derve be		ne (First, Middle, Ma		IICS					
arked atic ev	To Be	Philip A. Gan			erine M.									
n 27 Is ma er traum		19a. Informant's Name/Relation Nancy Harnish					Sykesvil							
nt: If item ry or oth			, , , , , , , , , , , , , , , , , , , ,											
Importar any Inju once.	1	Funeral Service		FIRM VI	ess of Facility Am	brose Fun g Rd., Ar	eral Home	i, Inc.						
		832 Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause only one cause on eac	sed the death. Do not en	iter the mode of dyi	ing, such as cardiac	or respiratory arres	it,	Approximate Interval Between					
sician		Immediate Cause (Final disease or condition resulting in death)	a. EN	D Stage	. Chmic Ol	hydrotice Pu	ilmny I) year	Onset and Death					
edical miner			Due to (or	as a consequence of):			U							
æ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or	as a consequence of):										
and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):										
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ing ph e as th	Medi	IF FEMALE:												
y the attend ched for us	ıysician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1□Live birtl 4□Pregnar 9□Unknow		23d. Date of d Month	elivery Day Year								
signed b	by Phy	Part II. Other significant condit	tions contributing to deat	h but not resulting in the u	underlying cause gi	ven in Part I.			to the cause of death? Probably 4 Unknown					
should	Completed						24a. Was an		autopsy findings available					
ate has	ошо						autopsy performe	prior to	completion of cause of					
ertifica ector, p	Be C	25. Was case referred to medic examiner?			lou		ath (Check only one)							
rthis o	: To	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp		III 3LI DOA	her: 4 ☐ Nursing H ırv at	lome 5 Residen	ce 6 Other (Sp	ecify)					
r: Afte ie fune	ation	1 Natural 5 ☐ Pend	/8 do 16-	Day Year) Injury	Wo	ork?]Yes 2 □No	200. 2000. 2010.	injury obodinou						
al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 400. Flaue UI	injury - At home, farm, si , etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	reet and Number or Rural Route Number, , State)						
To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical (est of my knowledge, dea s of examination and/or i stated.										
Tot	M	29b. Signature and title of certific	O Corn	1	29c. Licen:	1117	Λ.	d. Date signed (Mo	nth, Day, Year) 2003					
		30. Name and address of perso	KNOULCA	of death (Item 23a) (Type	W In 41V.	ostm.	the mo	21117						
Sta Registr		31. Date filed (Month, Pay, Yea.		istrar's Signature	me		The mo							

State of Maryland / Department of Health and Mental Hygien Certificate of Death

Physic	ian
/Med	ical
Exami	ner

Artis M. Lewis

1. Decedent's Name (First, Middle, Last)

2. Date of Death Month

06

Day

3. Time of Death 30 2008 12:20a M

Funeral Director

death with the Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director Funeral \$ Completed Be 0

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evan Physician /Medical

Examiner

Examiner

Completed by

Be

Medical Certification: To

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria ours after death.

leral Director: A
filled in by the fu within 24 hours a

To the Funeral C

completely filled

To the

a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Parkville Baltimore Genesis Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number Days 1 □ M 2√2 F 77 04 26 VA 212-30-3993 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Baltimore MD na 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 U.S.A. 5316 Hillen Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Private 4 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sally Ricks James I. Anthony 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5316 Hillen Road Baltimore, MD Leiola Matthews-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 7/3/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave 21215 March FH West jahan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspirchon Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 □No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown End shere demande Stax rend disease 24a. Was an

Physician/Medical

autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

decito itis wion coteo ma elito 25. Was case referred to medical examiner?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

and manner stated.

1 ☐Yes 2 ☑No 26. Place of Death (Check only one)

7000son

1 ☐ Yes 2 ☐ No

1 Yes 2 ₩10 27, Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Aursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D 31295

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIOESZ

11 N charles St 32 Registrar's Signature A SHOW

S. Te 4202

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Physician 6:42 P M July 5, Phuong Le Lam /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 236-19-2691 90 April 10,1919 China Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☑ No Silver Spring Director Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a or dicai Examiner must be 20901 513 East Indian Spring Drive Vietnam Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩Widowed 4 Divorced Hygiene. other than "natura ent, the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If Item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chau Thi Euc Lam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 513 East Indian Spring Drive, Silver Spring, Maryland 20901 Ky Gia Ly/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 Crematorium, Inc. Pumphrey Funeral 7557 Wisconsin 21. Signature of Funeral Service Licens M01498 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Cardiogenic Shock /Medicai Due to (or as a consequence of): Examiner Dilated Cardiomyopathy Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the burial-Physician/Medical as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an has autopsy performed? certificate ha 1□ Yes 2√ No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 🙀 Inpatient funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 ₩ Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital

State Registra

Medical

Maria J. Tayag 31. Date filed (Month, Day, Year) 0

29a. Certifier

(Check only one)

29b. Signature and title of

32 Registrar's Signature

2008

30. Name and address of person who completed cause of teath (Item 23a) (Type, Print)

Maria J. Tayag 1500 Forest Glen Road, Silver Spring, Maryland 20910

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D63579

29d. Date signed (Month, Day, Year)

July 6, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - State of Maryland /	Certificate of L		. •	2008	21725
	Dhini		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
4.	Physicia */Medic		Elvira E. Loss			June 29,		6:20A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Rockvill			4c. County of Death	37
- 000	Funeral		Collingswood Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last by	irthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgomer 9. Birthp	lace (State or Foreign
Ŀ	Director		578-46-3115 1□ M 2☑F 85	Yrs. Months Days	Hours Min.	(Month, Day, Y	1922 Ger	many
	yland low at			wn or Location			1	0d. Inside City Limits
	a-fsh ified	ctor	Maryland Montgomery Rocky	ville				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code		1 Ò g	. Citizen of What Cour	ntry?
	ath w		613 West Montgomery Avenue	20850	onanio Origina /Eng		nited Stat	
	items items ner n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Ves 2 ☑ No	13. Was Decedent of His If Yes, specify Cuba		Rican, etc.)	Black, White,	
20	urs af al", or :xami	þ	If Yes, Give 3	1 ☐ Yes 2X No	Specify:		Specify: Whi	te
0500-C	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupa (Give kind of work done d	lurina most of worki		6b. Kind of Business/In	dustry
Z	be filed within 72 hours after death with the Maryland ital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	'life. DO NOT use retired, Homemaker)		Own Home	
7	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me		12 17. Father's Name (<i>First, Middle, Last</i>)	Homemaker	18. Mother's Name	(First, Middle, Ma		
and		To Be	Joseph Kotzerke		Rosalie	Wolf		
5	should be t and Mental I s marked o umatic eve	ř	19a. Informant's Name/Relationship (Type. Print)	9b. Mailing Address (Street a	and Number or Rura	al Route Number, (
	12 m			751 Rockville				
E .	ges 1 a it of Hea if Item or othe		20a. Method of Disposition 20b. Place cemeit 1 X Burial 2 Cremation 3 Removal from State	of Disposition (Name of tery, crematory or other place	e) July	3, 20	c. Location - City or To	own, State
Ě	ment of I			lery, crematory variety place lawn Memorial Park	2008	P P	Rockville,	Maryland
Бащтог	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Licensee	Rockville, Rockville,	Inc. 300	West Mor	umphrey Fu	enue
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	Rockville,	Maryland g, such as cardiac	20850-2 or respiratory arres	2805 _{t,}	Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	200				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or is a consequir because of the consequir		-1			
	Examiner	Н	To V	or TO T	hriv	e ·		
	P #	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	e of):	2000			
P	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	e of):				
Ď,	icate be executed physician and s the burial-transit	al E	Due to (or as a consequence	e oi).				
6876 0,	death certificate be executed e attending physician and ed for use as the bunal-transit	edical	d					
X OX	n certi inding use a		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dea	ath 3□Ectopic pregnancy			23d. Date of deliv	
Ď	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 4 □ Pregnant at time of death	5 ☐ Other (specify)			Month	Day Year
r Ö	requires that the een signed by th hould be detache	Phys	9 Li Unknown		on in Port I	23a Did tobs	acco use contribute to	the cause of death?
Š,	res th signed be de	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause give	enin Faiti.	1 ☐ Yes		bably 4 □Unknown
ecord	requi	eted	Casarasy Asstern	0.10-8	-	24a. Was an		opsy findings available
ě	siclan: The law certificate has b irector, page 2 sl	Completed	Coronal Dilorg	000000	ę ,	autopsy	ed? prior to co	ompletion of cause of
			25. Was case referred to medical		26 Place of Deat	1 1 Yes 2 h Check on one	No 1 □Yes	2 1 No
5	ysicla iis cert direct	To Be	examiner?	Outpatient 3 DOA Othe			ace 6 Other (Spec	ify)
o c	d ing Phys h. After this funeral di		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b.	o. Time of 28c. Injury Work		28d. Describe hov		
<u>S</u>	tendli eath. or: A	catic	2 Accident investigation	1	Yes 2 □ No	00/1 // /01	to the second	al Doute Number
DIVISION	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office		City or Town,	eet and Number or Rui State)	al Houte Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 12 Certifying Physician: To the best of my knowled	lge, death occurred at the tir	ne, date and place,	and due to the ca	use(s) and manner as	stated.
	he Ho n 24 h he Fu pletel)	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.					
	To t To t	Σ	29b. Signature and title of coefficien	29c. Licenso	e number	29	d. Date signed (Month	, Day, Year)
			132/M	1000	0045	7	0/50/	200
	12		29b. Signature and title of coefficier 30. Name and address of person who completed cause of death (Item 23s 5 A 4 E) E S A 9 1 A 9 5 7 5 8 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	Media (late ,	& Roc	KuilleA	1020850
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Striature	peres		, , ,		
	Regist		JUL 0 7 2008					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Patty G. Larmore 30 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbur Hospice WICOMIC If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕅 F 76 434-42-6637 Aug 15, 1931 Louisiana Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No MD Wicomico Salisbury Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1110 Healthway Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 Married aryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un . 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Quzts N. S. Green 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1110 Healthway Drive Salisbury, MD Eugene Larmore/spouse altimore./M permit. Pages 1 an Department of Heali Important: If item 2 any Injury or other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signarure of Funeral S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Hart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme Le Cause (Final disease or condition resulting in death) MAHGNANT Physician CARCINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death detached 9□Unknown 9 Unknow þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐ Unknown 1 □ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsv performe certificate 2 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 0 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A
completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

COASTAL Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

SPICE

29c. License number

29d. Date signed (Month, Day, Year)

8.0 Bo x 1733 SAUS BLING UD 21802

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Funeral Director

	For State of Maryland State of Maryland		artment of H <i>rtificate of E</i>		Mental Hy	giene Reg. No	008	21727
n Il	Decedent's Name (First, Middle, Last) Charles		McKnight		2. Date of De Month June 2	ath Day	Year	3. Time of Death 7:20 A
r	4a. Facility Name (If not institution, give street and number) Prince George's Community Hospita	a1	4b. City, Town, or Chever1	У			County of Deat	eorge's
	5. Social Security Number 248-52-5663 0	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ay, Year)	9. Birt	thplace (State or Foreign ountry) tth Carolina
	10a. State 10b. County 10c. City, 7	Town or Lo						10d. Inside City Limits 1 🎇 Yes 2 🗌 No
	10e. Street and Number	LOVI	10f. Zip Code				en of What Co	ountry?
	10 ∩ Hill Road 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No		20785 Was Decedent of His If Yes, specify Cubar	n, Mexican, Puer	Specify Yes or No to Rican, etc.)	U.S.	A . 4. Race - Ame Black, White	
	3 ☐ Widowed 4 【 Divorced Year or Dates: Unknown (Specify only highest grade completed)	WN 16a. Dece	1 ☐ Yes 2 X No edent's Usual Occupa		rkina		Specify: B1a d of Business/	ack Industry
Paralle la la la la la la la la la la la la la	Elementary/Secondary (0-12) College (1-4or 5+)	life.	aborer				dscapi	ng
	17. Father's Name (First, Middle, Last) Govan McKnight				me (First, Middle		Surname)	
1	Sandra Fleming (Daughter)	100 н	ng Address (Street a		ille, Ma	rylan	d 207	85
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	etery, cře ce r C	osition (Name of matory or other place emetery	7-3-	Date -08		ter, So	
	21. Signature of Funeral Service Licensee		2. Name and Addres Jobs Morti 312 S. Ma:	uary	Sumter.	SC 2	9151	
	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Aspirat Due to (or as a consequer Severe Swallo	ion ince of):	Pneumonia	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
Due to (or as a consequence of): Cause (Disease or injury that inflitated events resulting in death) Last Due to (or as a consequence of): Advance Emphysema Due to (or as a consequence of): Melignant Cachexia								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal deaded 4 □ Pregnant at time of deaded 9 □ Unknown	eath 3	☐ Ectopic pregnancy			2	3d. Date of de Month	livery Day Year
5	Part II. Other significant conditions contributing to death but not resulting Bullous Disease of Lungs	ng in the u	ınderlying cause give	n in Part I.				o the cause of death?
-	Left Upper Lobe Mass				24a. Was auto perf 1 □Yes			utopsy findings available completion of cause of
	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1☒ Inpatient 2 ☐ EF			r: 4 🗆 Nursing	eath (Check only Home 5 Res	idence 6		ecify)
	1 Matural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	Bb. Time of Injury	M 1□\	rat ? /es 2 □ No	28d. Describe			10
	4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify) 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowle			no data and alac	City or To	wn, State)		ural Route Number,
	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.			oinion, death occ		, date and	place, and du	e to the cause(s)
	29b. Signature and title of certifier Selfclufp'. M.	0.	D2120				25, 20	
	30. Name and address of person who completed cause of death (Item 2 Shriniuas R. Udapi, MD 7245	B La	Print) andover Pa	arkway,	Greenbel	lt, M	D	
e r	31. Date filed (Month, Day, Year) 2008 2. Registrar's Signatur	Soo	ele.					

			State of Maryland / Department of Health Certificate of Death	and Mental F		8 2	1728
			Decedent's Name (First, Middle, Last)	2. Date of	Reg. No. Deeth		3. Time of Death
	Physici		LILLIE RUTH MILLER	Month	20	O8	5:36 am
)	/Medic Examin			own, or Location of De		y of Death	J. 20 com.
	Examili	iei		con	Balt		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24 Hrs. 8. Date of	Birth		ce (State or Foreign
	Director		214-24-2580 1 M 27.5 81 Yrs. Months Deys Hours	Min. (Month,	21, 1926	Country	N.C.
	_		Usual Residence of Decedent				
	nylan how		10a. State 10b. County 10c. City, Town or Location				. Inside City Limits
	e Ma	cto	MD N/A Balto				1 KYes 2 No
	or 28	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of	What Country	?
	23e		3 Liberty Place 21244	4	τ	J S A	
	dea .	Funerai	11. Marital Status 12. Wes Decedent Ever in U,S. 13. Was Decedent of Hispanic Or If Yes, specify Cuben, Mexice	rigin? (Specify Yes or	No- 14. Ra	ce - American	
Ö	or it	F	1 Never Married 2 Married 1 Yes 2 No		Specia		Lack
Maryland 21215-0020	irel',	d by	% Widowed 4 □ Divorced Year or Dates:		оросп	y. D1	.uck
<u>7</u>	netu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during mos	st of working	16b. Kind of B	usiness/Indus	unk Unk
2	vithir ne. hen	ď	Elementary/Secondary (0-12) College (1-4or 5+)				
N	iled v tygie her t nt, th			er's Name (First, Mid	dla Maidan Suma	mal	
ŭ	be for the part of	Be			die, Maideri Surriai	пөј	
Ž	2 should be filed within 72 hours after death with the Maryland send Mental Hygiene. I be marked other than "neturel", or items 23e or 28e-f show le marked other than "neturel", or items 25e or 28e-f show reumatic event, the Medical Examiner man be notified at	٦ ا	1.00000	a Mae		0:-4- 7:-0	-4.1
Σ	h en h en r le r		19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb				30e)
ψ	Heelth Heelth Hem 27 I		Derrick Miller- Son 2402 Wilgrey Ct 20a. Method of Disposition (Name of	L Balto,	MD ZIZ.		State
ŏ	Pages nent of I int: If Ite		1 □ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)				
≣	tmer tant:		4 Donation 5 Other (Specify) Woodlawn Cemetery	1	Balto		עני
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelith and Mental Hydene. Important: If Item 27 is marked other than "neturel; or items 23e or 28e-f show eny injury or other treumatic event, the Madical Examiner must be notified at once.		21. Signature of Funer Service Licensee 22. Name end Address of Facility				
_	9D = 9 Q		Sparlilleller 1101 E. Nort	th Avenue	e Balto	, MD 2	21202
1	Physician /Medical Examiner	e	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart feliure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) e. Due to (be sa ponsequence of):			0	itérvel Between Inset end Death
	cete be executed physicien end s the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or es e consequence of): c. Due to (or as e consequence of):	an-	VED BY MEDICAL EXA	WP	
8/60,	sicial s buri	dicai	Cause (Disease or injury that initiated events Due to (or as e consequence of):	GENTI TONING THE	ES SI BELIANCE	MINER	
٥	certifice nding phy use es th	Ф	resulting in death) Last				
	eeth certific ettending p	Physician/M	d				
מ	0 0 %	SICI	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part	I. 23b. D	id tobacce uee co	ontribute to th	ne cause of death?
j S	requires thet the de een signed by the e hould be deteched	Ph.	in his time of the said	1	EYes 2□ No	3 Probat	bly 4 ☐ Unknown
- ທົ	res thet igned to be det	þ	carnon acteur disease				
00	v require been si should I	De le	Carrier altere desearce	24a. W	es en eutopsy formed?	evaila	eutopsy findings able prior to
ပ္ပ		be	- carmany acting access			of dea	pletion of cause ath?
r	The late h	Completed		1	□Yes 2☑No	1□Y	res 22 No
VITal	sician: The law certificate hes t director, page 2 s	Be (25. Was case referred to medical example? 26. Place	e of Death (Check on	ly one)	lana	intral.
5	Physician: rthis certific rral director,	၉	Hospital:	ursing Home 5 🗆 R	esidence 6 🗹 Ott	her (Specify)	lime
	ding Phys h. After this funeral d	ä	27. Manner of Seeth 1 □ Newtral 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? Work?	28d. Descril	oe how injury occu	rred	and the same of th
<u> </u>	Attending or death. Sctor: After by the fune	cati	2 Accident investigation 6/4/08 11.35 AM 1 Yes 2/2	. 201		CE/FI	ELL
JIVISION		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street and Num Town, State)		Route Number, ELVILLE
2	ital or irs effe rel Dir lled in		COLLEGE MANOR	300 W, 56	MINARY	MD 2	1093
	Hosp 4 hou Fune lefy fi	edical	29a. Certifier (Check only (nd place, and due to t ath occurred at the tin	he cause(s) and m ne, date and place,	anner es state and due to th	∍d. ne cause(s)
	To the Hospital or within 24 hours effe To the Funerel Dir completely filled in	Med	and manner stated.				
	5 <u>₹</u> 6 0		29b. Signature and title of certifier 29c. License number		29d. Date signe	(WOHIII, Da)	,, ruaij
)			· Such Josewilly D24/2	-/	6/30/	08	
/	17		30. Name and eddress of person who completed cause of deeth (Item 23a) (76e, Print) BRUCE ROSENBERG 21 WEST RD 7	TOWSON	MD 2	1204	
	Sta Registra	-	31. Date filed (Month, Day, Year) JUL 0 7 2008 32. Refistrer's Signature	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04976 State of Maryland / Department of Health and Mental Hygiene Johnny Patterson 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 27, 2008 1910 hrs Medical Examiner Patterson ohnny 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** NA Union Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Country) Pary Rus Director 9-78-9842 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Baltimore Xes 2 No Maryland , or items 23a or 28a-f show r must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, Director 10g. Citizen of What Country 10e, Street and Number arclay Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Never Married Yes Yes 2 No specify: If Yes. Give Yee Widowed Δ Divorced 9 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) eriotek Staffina Baltimore, MD 21215-0036 UDENVISOR 18 Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) illinger (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Info ant's Name/Relationship (Type, Print) 19b. Mailing Address l+o MO 21218 Savela anessa 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Cremation 3 Removal from State 7/2008 Metro Coemater Bonation 5 Other Specify 22. Name and Address of Facility ignature of Funeral Service License MO 21229 Tton Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death Medical Cocaine intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and 10c per th g881 7-7-08 23a,PII,27,28a-f, perME Physician/Medical X UNPENDED AMENDED signed by the attending physician be detached for use as the burial perME,g881 7/8/08 TT the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown ģ Hypertensive cardiovascular disease After this certificate has been sign funeral director, page 2 should be Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? performed? ✓ Yes No 2 Yes 2 26.Place of Death (Check only one 25. Was case referred to medica Division of Vital Be Hospital: examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 No 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Yea 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Yes 2 X No unk Natura! Director: A Pending Fnd 6/27/08 Fnd 6:30 pm 24 hours after death. 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 3226 Barclay St Baltimore, MD Suicide determined (Specify) found at residence To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 28, 2008 O.C.M.E. 0 of persyl who completed cause of death (Item 23a) 30. Name and address Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 DOME Mary G. Ripole MD. 31. Date filed (Monti State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1607 Bessie Pinkney 08 2:00a 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore
nder 1 Year | If Under 24 Hrs. If Und 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 94 Yrs. 212-26-5682 Director 07/05/13 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, "the "had call Explain in it, ust be notified at Director 1 ☐ Yes 2 No Baltimore Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21207 3501 Howard Park Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Black 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self-employed Tailor 2 yrs 2 should be filed w h and Mental Hygie Is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Etta Reeder John Thomas 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If Item 27 is any injury or other trau 21201 473 Oxford Court MD Baltimore, <u>Gloria Johnson</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Park 07/10/08 Arbutus, Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue Junam March FH West 21215 Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consi Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 50 Due to (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2\2\No 2 No **Division of Vital** 1 ☐ Yes 1 □Yes Physician; 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Man er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, degistrar's Signatur Year) 0 Registrar

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State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** /Medical Examiner If Under 1 Year Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 ☐ M 2 ☐ XF Hours Months Days 82 003-14-5818 24 1925 Oct Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Sykesville 1 ☐ Yes 2 📉 No MD Carrol1 Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be re 21784 USA 7200 Third Ave. C102 Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced ear or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education and Mental Hygiene educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Woods Arthur W. Machen ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7200 Third Ave. C102, Sykesville, MD 21784 C. Harvey Palmer (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 7-9-08 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License C typical yours P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☐ ER/Outpatient 3D DOA 5 ☐ Residence 6 ☐ Other (Specify) Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mann Certification: (Month, Day Year) Injury Natural 5 Pending investigation within 24 hours after use....

To the Funeral Director: After the Funeral Director of the funeral of the funera 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		•	For State Registrar	State of Ma	aryland /	Depa Cer	rtment d <i>tificate</i>	of Heal of Dea	th and ath	Mental Hy	giene Reg. No	200	8	21	733
	Physici	an	1. Decedent's Name (First, Middle							2. Date of De Month	Dat	You Ye	ear .	3. Time of	
4.	/Medic	cal	Annetta Mae Po 4a. Facility Name (If not institution				4b. City, Tov	vn. or Locat	tion of Deat	June 28		008 County of I		12:40	AM
•	Examin	ier	Northwest Hosp	-			Randallstown					altimo			
	Funeral		5. Social Security Number		e (In yrs. last b		If Under 1 \	ear If Ur	nder 24 Hrs	8. Date of Bil (Month, Date	th ay, Year)		Count	ace (State	or Foreign
	Director		215-30-6074 Usual Residence of Decedent	ППМ ZЩ Р	74	Yrs.				Mar 13	, 19	34 M	aryl	and	
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation						10	d. Inside C	ity Limits
	a-fsh	ctor	MD Anne	Arunde1	G	1en	Burnie							1 ☐ Yes	2√ No X
	ith the	Directo	10e. Street and Number				10f. Zip Co		•		10g. Cit	izen of Wha	t Count	ry?	
	eath w		903 Jay Cour	12. Was Decedent I	Ever in IIS	13 \	Vas Deceden	2106		Specify Ves or No	. 1	USA 14. Race	America	n Indian	
36	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, it is Redical Exercities must be redified at	by Funeral	 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 	Armed Forces?			Yes, specify		xican, Puer	Specify Yes or No to Rican, etc.)			White, et	tc.	
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2	filed w Hygie ther t	ပိ	12 17. Father's Name (First, Middle,	5+ Last)		teac	her/pr	-		me (First, Middle	L	educa Surname)	L 101	l.	_
au	ev d	To Be	Charles Howard							a Rehlin					
Maryland 21215-0036	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Item Me	-	19a. Informant's Name/Relations	hip (Type. Print)	15	9b. Mailin	g Address (S	treet and N	umber or R	ural Route Numb	er, City o	or Town, Sta	ate, Zip	Code)	
χ. Σ	and 2 lealth m 27 i		Raymond Poff/s	pouse	1				len B	urnie, N		21061			
altimore,	Pages 1 ment of h ant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S		20b. Place cemei	of Dispo: tery, cren	sition (Name in atory or othe	of r place)	1 1 1 4	Date	20c. L	ocation - Cit	y or 10v	vn, State	
Ball	permit. Page Department of Important: If any Injury or once.		21. Signatur Funeral Service Ronal	111110		Ba	1timor	e, MD	212			Ltimor	e St	treet	
			23a. Part 1. Enter the disease or shock, o heart failure. List	complications that caused only one cause on each lir	the death. Do	o not ente	er the mode o	f dying, suc	ch as cardia	c or respiratory a	ırrest,			Approximate Interval Be Onset and	tween
4.	Physician /Medical		Immediate Ca (Final disease or condition resulting in death)		AGE AL		IMER I	Distat	SE				\perp		
	Examiner		,	Due to (or as	a consequence	e of):									
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed experience)	b. Due to (or es	а попведиело	6.90									
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68760,	ficate g phys s the	edical		d											
Box	eath certifi attending for use as	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		th all	Ectopic preg	nanav				23d. Date o	of delive	,	
O. B	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (speci					Month		Day	Year
٠ <u>.</u>	that the de ned by the a detached t		Part II. Other significant condition	ons contributing to death be	ut not resulting	in the ur	iderlying caus	e given in F	Part I.	23e. Did	tobacco	use contribu	ite to the	e cause of	death?
rds	w requires t been signe should be o	ed by								1 🗆	Yes 2	□ No 31	☐ Proba	ably 4□	Unknown
ဝပ္ပ	law re as bee 2 sho	plet								24a. Was		24b. We	re autop	sy findings	available
<u> </u>	The ate h page	Completed									ormed?	dea	th?]Yes	-	
Vital Records,	Attending Physician: The death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor		ath (Check only				SENSO	W.
	Physer this eral dii	<u>1</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		. Time of		Injury at	Nursing	Home 5 ☐ Res 28d. Describe			(Specify) Ttosi	
<u>o</u>	nding F ath. r: After ie funera	atio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		y, Year)	Injury	м	Work? 1 ☐ Yes	2 🗆 No						
Division of	al or Atte s after de Il Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, c. (Specify)	farm, stre	eet, factory, of	fice		28f. Location City or To			or Rural	Route Nur	nber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical (29a. Certifier (Check only one) 1 Certifylr 2 Medical	ng Physician: To the best Examiner: On the basis o and manner sta	f examination a	lge, death and/or in	occurred at vestigation, in	the time, da my opinion	ate and place n, death occ	ce, and due to the curred at the time	cause(s , date an	s) and manr d place, and	ner as st d due to	ated. the cause(s)
	To the comp	M	29b. Signature and title of certifie				29c. L	icense num	ber		29d. Da	ate signed (/	Month, L	Day, Year)	
			> Nullah	Keen				4593			JUY	1028	29	08	
			30. Name and address of person	0-00	eath (Item 23a		1	7576Y	LSTOW	N MO					
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	4	NO 100								
	Registr		JUL V (ZI	JUO ABOUT	1.	3024									

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month JOHN MERCER PARKER JULY 2008 6:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL LORIEN NURSING CENTER MT. AIRY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 83 219-16-7105 10/31/1924 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No MD CARROLL NEW WINDSOR 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1301 SOMERSET CT 21776 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Folices: 1 X Yes 2 No If Yes, Give KOREAN Year or Dates CONFLICT 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAIL MAN POSTAL SERVICE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PARKER, JR. LEOLA CECILIA NORRIS JAMES Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BRUCE E. SNYDER -STEP SON CT., NEW WINDSOR, MD 21776 1301 SOMERSET 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date /7/08 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) OWINGS MILLS, MD CÉM. GARRISON FOREST VET 4 □ Conation 21. Signature of neral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. MD 21157 WESTMINSTER, 254 E. MAIN ST., Approximate Interval Between Onset and Death 23a. Part1. E to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): nemia Due to (or as a consequence of): IF FEMALE: 23c. If ves, outcome of pregnancy 23d Date of delivery

Physician /Medical Examiner

Physician

Examiner

Director

Funeral

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Completed

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Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2:3 Department of Health a Important: If item 27 is any Injury or other trau

/Medical

attending physician and for use as the burial-transit Exami Completed by Physician/Medical

n signed by the and d be detached fo peen a cate has

P.O. Box 68760

Division of Vital Records,

the death certificate be executed e Hospital or Attending Physician: 7 24 hours after death. Puneral Director: After this certifica filled in by the funeral To the within 2

Be

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

7 2008

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23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year
Part II. Other significant condition	as contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Immobility	syndrome	24a. Was an autopsy performed? 1 □ Yes 2 ■ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ■ No
Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ❷ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ■ Nursing Home	e 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day, Year) Injury Work?	d. Describe how injury occurred
3 Suicide 6 Could no determin		if. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, ar xaminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

GYI

State Registrar 82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Wild Registrar		Certificate of L	Death	Reg. N	_	21735
	Physicia	an	1. Decedent's Name (First, Middle, Last)	15 10.1				Day Year	3. Time of Death
4.	/Medic	al	4a. Facility Name (If not institution, give street and number)	linski	th Oth Town or	Location of Death	uly 2	2008 4c. County of Death	2150 P M
	Examin	er	Johns Hopkins Bayvicus Medic	al Center	Baltim			tc. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs. 8. D Hours Min.	Date of Birth Month, Day, Yea /08/194	9. Birth	place (State or Foreign intry)
	Director		216-98-2269	60 Yrs	5.	11	/08/194	7 Pola	nd
	yland now		10a. State 10b. County	10c. City, Town o	r Location	_			10d. Inside City Limits
	e Mar 3a-f sh liffed	ctor	Maryland Harford	Edgewoo	xd				1 □ Yes 2√2√No
	with th	Dire	10e. Street and Number		10f. Zip Code			Citizen of What Cou	ntry?
	reath ns 23	Funeral Director	1904 Cherry Place 11. Marital Status 12. Was Decedent	Ever in U.S.	21040 13. Was Decedent of H	ispanic Origin? (Specify n, Mexican, Puerto Rical		LAND 14. Race - Amer	ican Indian,
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Eventian must be notified at		Armed Forces? 1 □ Never Married ★★ Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 □ Yes 2 27No	n, Mexican, Puerto Rical Specify:	n, etc.)	Black, White, Specify: Whi	
15-0	"natu	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup Give kind of work done o fe. DO NOT use retired	ation during most of working	16b.	Kind of Business/I	ndustry
12	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Inc.Ms	omp	Elementary/Secondary (0-12) College (1-4or 5	(cour		,	c	ourier	
pu	e filed al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)	'		18. Mother's Name (Fire		en Surname)	
ylai	ould b I Ment narked natic e	5	Stanislaw Szulinski			Alicja Brz			
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Jaroslaw Szulinski (Son)	1	,	and Number or Rural Ro ntiago, N.E			
re,	s 1 an of Hea item 2	1 4	20a. Method of Disposition		isposition (Name of crematory or other place			Location - City or T	
imo	Page ment c ant: If ury or		1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	l .	v Crematory	07/08/2		ltimore,	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau	(21. Signature of Toperal Septice Licensee		22. Name and Addres Br 1407 Old	ůžďžinski F Eastern Ave	uneral nue, Es	Home, P.A sex, Mary	land 21221
			23a. Part1. Example 1 fise ase, or complications that caused shock in heart failure. List only one cause on each list	the death. Do not	enter the mode of dyin	g, such as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
The same	Physician /Medical		Immediate Cause (Final diseas) or condition resulting in death)		ufficiency				
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	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due t (or as Cause (Disease or injury that initiated events resulting in death) Last	Injury		GENTIFICATION APPROVI	ED BY MEDICAL EX	AMINER	
90,	rificate be executed by physician and as the burial-transit			a consequence of):		10			
68760,	icate by physic s the b	Medical	d. IVIDTO	rvenici	e Collisio	<i>V</i> 1			
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deli Month	very Day Year
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death b	ut not resulting in th	ne underlying cause give	en in Part I.			the cause of death?
Records,	The law require cate has been si page 2 should t	Completed					24a. Was an autopsy performed 1 □ Yes 2	prior to c death?	copsy findings available ompletion of cause of
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death (Ch		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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Division	I or Attendi after death. Director: A d in by the fi	Certification:	of Could not be		street, factory, office	28f. I		-	ral Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Physician: To the best (Check only one) 1 Medical Examiner: On the basis of and manner st	f examination and/					
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	5								
l	105		30. Name and address of person who completed cause of c	leath (Item 23a) (Ty	pe, Print)	RALTIMORE,	ND 2	1224	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Sparke

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 7, 2008 Shirley May Spare 4:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore 918 Foxwood Lane Essex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🛛 F Hours 217-40-4815 **Director** 63 11/04/1944 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits nt of Health and Mental Hygiene.
If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination until to inviting at Director 1 ☐ Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 918 Foxwood Lane 21221 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐KNo þ Yes, Give Specify: White 3X Widowed 4 ☐ Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Fabian Emma Virginia Horlacker မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Commodore Drive, Baltimore, Maryland 21221 Tammy Jenkins (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page: Department o Important: If i any Injury or ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 07/10/2008 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur, of Funeral Service Licensee 22. Name and Address of Facility Inski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE PUZMONARY **Physician** disease or condition resulting in death) YEMRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) P.O. Box 68760. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: Hyperlysidemia 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 220 MM 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 FERNANDO BALTIMORE 31. Date filed (Month, Day, Year) 37 Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

08-05150 Dennis St. Clair Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ennis St. Clair	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar 1-For State Registrar Amend #16a PerFH G881 Certificate of Death Reg. No.	2173
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Franklin Square Hospital 4c. County of Death Rosedale Baltimore County	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Social Security Number 1 X M 2 F 65 Yrs. Months Days Hours Min. 4/24/1943 Foreign Country)	
	Usual Residence of Decedent	
nd Chow any	1 ¬ 1 ¬ 1 ¬ 1 ¬ 1 ¬ 1 ¬ 1 ¬ 1 ¬ 1 ¬ 1 ¬	de City Limits es 2 X No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
with the is 23a or e notific	7 Right Aileron Street 21220 U. S. A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American India)	n, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sheal Examiner must be notified at once leted by Funeral Director	13 Widowed 4 Divorced III Yes, Sive Yeard O.C.4. 4 O.C.E. 11 Ves. 2 VI No. energy: 150ects: 140 to 150ects: 140 to 150ects:	·
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner Completed by I		
03(12 Ladorer Laborer Steel Mill	
21215-0036 ould be filed within 7 i Mental Hygiene. I marked other than ic event, the Medica To Be Comple	77. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruth Irene Mowery	
should the and Men Tis mar	2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code	-7
ant da Z	Patricia Ann St. Clair (Wife) 17 Aileron Street Middle River, Maryland 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 7/10	
	4 Donation 5 Other Specify: Bayview Crematory 2008 Baltimore, Mar	ryland
Balf permit Depart Impor injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland	21221
Physician 'Medical	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	kimate Interval en Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Carbon Monoxide Intoxication complicated Hypertensive Atherosclerotic Cardiovascular or condition resulting in death)	
iner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause Cour	
executed an and al- transit cal Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
sici be	UNPENDED AMENDED	
6876 certificat anding phi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
ords, P.O. It we requires that the sas been signed by the should be detached pleased.	1 Yes 2 No 3 Probably 4	
0 = = C c	24a. Was an autopsy find prior to completion death? 1 Yes 2 No 1 Yes	
Vital Recysidan: The his certificate director, page	25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 4 Inspiral 2 FB/Output only 20.Place of Death (Check only one)	
on of Virunding Physically. T: After this be funeral direction:	27 Manner of Death 29a Date of Injury 29b Time of Injury 29c Injury at Work2 29d Describe how injury occurred	
Division o ospital or Attending hours after death. Inneral Director: Aft y filled in by the fune. Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 2 Accident Investigation Investigation 5 Suicide 6 Could not be determined 1 Homicide 2 Accident 1 Investigation 1 Jul 4, 2008 2232 hrs 288. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State) 3301 Edwards Lane, Bowleys Quaters, Md	Number, City
Division To the Hospital or Attendenth in 24 hours after death To the Fineral Director: completely filled in by the Medical Certification		5)
S S S S S S S S S S S S S S S S S S S	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, July 5, 2008	Year)
2011	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra	te 31. Date filed (Month, Day, Year) 2008 32. Registrar's Signature	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FRANCES BOLINGER SMITH JUN 24 2008 12:48 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 5 Social Security Number 6 Sev 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗶 F Director 80 414-46-0881 25, 1928 Jan. Tennessee Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director VA Fairfax Clifton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12812 Knollbrook Drive U.S.A. 20124 Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23sury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Fairfax County Elementary/Secondary (0-12) College (1-4or 5+) Teacher School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Bolinger Sallie Mae Wolfe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Smith / daughter 12812 Knollbrook Drive, Clifton, VA 20124 20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National

Cemetery, 22. Name and Address of Facility 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of Important: If It any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation—5 ☐ Other (Specify) July 1,2008 Triangle, Virginia 21. Signature of Funeral Service License um Pierce Funeral Home, 9609 Center St., Manassas, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛛 No 9□Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No. neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

within 24 hours at To the Funeral C completely filled it

State

Registrar

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALKER . Registrar's Signature

Walker, MD

29c. License number

0101237003 (VA)

29d. Date signed (Month, Day, Year)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

June 25, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
Red. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** vens umer JUna 27 3008 6:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 08 Hospital Baltimore CH.

If Under 1 Year If Under 24 He

Months Days Hours Min. Baltimore 2675 8. Date of Birth (Month, Day, Year) Sept. 30, 19 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 9-62-8859 125M 2□ F Director runil Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☐ No 3 □ Widowed 4 Divorced Specify: þ Completed 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12.H Department of Health and Mental Hygie Important: If Item 27 is marked other in Important; or other traumatic event, <u>It</u> Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Wilmen ျှ Mamie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley 5301 ronica Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date Garrison 1 Qurial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of neral Service Ligensee 22. Name and Address of Facility Approximate Interval Between Onset and Death the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Immediat Cruse (Final disease or andition resulting in death) **Physician** neumonio /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a sequence of) Examiner The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p use as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached t 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 ... Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 □Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsy this certificate 2 No or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA within 24 hours after occur.

To the Funeral Director: After this 27. Mariner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 / Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0063/21 008 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Belvalere Baez 2401 West 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUL 9 7 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21740 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Rita Salvatore 2008 2:20p Ju1_v 4a. Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2√2 F Months 156-48-5295 April 9 1954 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Marriottsville Howard 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2120 Whitman Way 21104 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) information technology account manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patricia Colbert Daniel Charles Curry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Salvatore, Jr. (spouse) 2120 Whitman Way, Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 National 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. View Cemetery 7-10-08 Marriottsville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Pargrafaight Herbert P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mytastatic to lun BREALT 9 31HA) Due to (or as a consequence of): Disk to for as a nonsequence of Due to (or as a consequence of):

Ye ar

2 No

29d. Date signed (Month, Day, Year) 7-7-04.

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

Medical

Physician

/Medical

Examiner

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Funeral

Director

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filed within 72 hours after Hygiene.

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permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked on any Injury or other traumatic ev

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-trar signed by the a peen has page 2 s his certificate h I director, page this funeral After

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 ☐Yes 2 No 5 ☐ Other (specity) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pleural をたとっかいい? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) \(\text{Nc} \times \text{E} 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hosp within 24 ho To the Fune completely f

State

29a, Certifier

(Check only

29b. Signature and title of certifier

ND

Minfind

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

n 24 hours after death.

e Funeral Director: A pletely filled in by the fu

death.

29c. License number

0 30573

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ö

or Items 23a

"natural",

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medis once.

the Medical

Examiner must be notified at

Director

Funeral

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Completed

Be ဂ

with the Maryland

1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Krenson Mari

attending physician the this within 24 hours after death.

To the Funeral Director: After in by the

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be မ Certification:

IF FEMALE: 23b. Was decedent pregnant □Yes 2□No 9 Unknown

27. Manner of Death

1 A Natural

2 ☐ Accident

3 Suicide

5 Pending investigation

6 Could not be determined

1 / Impatient 28a. Date of Injury (Month, Day Year)

2 ☐ ER/Outpatient 3 ☐ DOA 28h. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier ticrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

Medical resident

29c. License number

29d. Date signed (Month, Day, Year)

Good Some and oldress of person who completed cause of death (Item 23a) (Type, Brint)

10 KOVEVQ 5601 LOCK ROWN 814 Be 14 MORE 30. Name YOKOVEVR

State Registrar

1

Medical

31. Date filed (Month, Day, Year)

2008

32. Registrar's Signature Mary or

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name First, Middle, Last) Month Year Physician 12:35PM 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgemery Montgemery Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apt.#7 Montgomery Co. Clearshot Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** 1**⊠**M 2□F Scoul, 226-92-9181 Usual Residence of Decedent 07/21/1919 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Montgomery Director MD 10g. Citizen of What Country? 10e. Street and Number 20906 United States Z812 earshot Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify: specify: Kurean à 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 45 iness man Ketail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 51 Shin HWang ည on a 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burke 9624 Sookhee rark /daughter view ave. 22015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 07-07-08 Brentwood, MD Lincoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 933 Gist Ave, Services. Silver Spring, MO 20910 BRUCE 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. not anter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Apple 1 Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown cate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant contributions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 No 1 TYes 2□ No 25. Was case referred a medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Desidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner at Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Multural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760,

or Attending Physician: within 24 hours after death. To the Funeral Director: completely filled in by To the Hospital

Registrar

Medical

29b. Signature and title of certifier

29c. License number

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, P

31. Date filed (Month, Day, Year)

0

29a. Certifier (Check only one)

			For	State of Maryland			Mental Hygi	iene anno	2171.2
			State Registrar		Certificate of	Death		eg. No. 2008	
п	Physicia		1. Decedent's Name (First, Middle, Last ANTHONY)	STEWART		2. Date of Death Month JULY	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town,	or Location of Death		4c. County of Death	
			The Johns Hopkins Ho		Baltimor				
	Funeral Director		217-10-2700	7. Age (In yrs. la	(1) Ast birthday) If Under 1 Year Months Day		8. Date of Birth (Month, Day,	Year) _ Cour	place (State or Foreign
Pue	show		Usual Residence of Decedent 10a. State 10b. County		Town or Location				10d. Inside City Limits
Many Many	28a-f sh	Director	M () 10e. Street and Number	tha	Himure 101. Zip-Code		10	ng. Citizen of What Cou	1 Yes 2 □ No
ath with	s 23a or ust be n	iral Dir	3014 Rayner		212	216		USA	
036 s affer de	should be fact within 12 hous are used well with the waysand the the think the waysand marked other than "natural", or thems 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces?. 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Baltimore, Maryland 21215-0036	"natura ledical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Şecondary (0-12)		16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	ne during most of wor		16b. Kind of Business/li	
212	r thar	E O	Elementary/Secondary (0-12)	College (1-4 of 5+)	Chef			Food Serv	1100
פר	Mental Hygiene arked other than arked other than atic event, the M	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, M	Maiden Surname)	
Xa Xa		P	Charles Wh	rte	`	theling	la steu	vart -	
Aaryla 2 should	is m		19a. Informant's Name/Relationship (7)	0 1	19b. Mailing Address (Stre	A	77 1	City or lown, State, 2i	p Code)
e,	of other traumatic		Charlene Mani		ace of Disposition (Name of	1er Avenu		20c, Location - City or T	own, State
סר	nent of Hes net: If Item iry or othe		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	metery, crematory or other p	/ace) 7 C	-08	Botto. N	d
			21. Signature of Funeral Service Licens		22. Name and Add	dress of Facility	Wahn G	Greene F	unenil Sus
8	Departr Importa any inj		Vaughn	C. Heepne	5151 R	a Ho. Nat	ional Pi	Ke Balti	Md. 21227
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	. Do not enter the mode of o	lying, such as cardia	or respiratory arre	est,	Approximate Interval Between
Р	hysician		Immediate Cause (Final disease or condition	a CARDICPULMO	NARY A	RREST			Onset and Death 45 M(N
	Medical xaminer		resulting in death)	Due to (or as a consequent					
4 -	.xammer	<u>-</u>	Sequentially list conditions,	b. SERSIS Due to (or as a nonseque	no di				1/2 MONTH
7-8	nsit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		YELOGENOUS	LEUKE	NA 1 A		5 MONTHS
,	al-trar	Ä	that initiated events resulting in death) Last	Due to (or as a consequence		LEONE	<u> </u>		5 1.1011(11)3
Hecords, P.O. Box 68760,	one be executed by sician and the burial-transit	dical		, d					
687	g phy as th	00	IE SELAN E						
XO	attending ph	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal		ancy		23d. Date of deliment	very Day Year
P.O. Box	he att	ysici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	ath 5 Other (specify)			No.	54,
P.C	been signed by the a should be detached	P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying cause	given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds,	signe d be	d by					1 ☐ Ye	es 2 ZÍNo 3 □ Pro	bably 4 🗌 Unknown
S	v requ	Completed					24a. Was an		topsy findings available completion of cause of
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ig ig	ysician: The is s certificate ha director, page	Be	25. Was case referred to medical			26. Place of Dea	th (Check only one		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ysicia is cert direc	일	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 DOA	Other: 4 Nursing H	ome 5 🗆 Reside	nce 6 Other (Spec	ify)
0 2	After thi		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury W	ijury at /ork?	28d. Describe ho	ow injury occurred	
Sio	terion leath. lor: At the fu	cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 me, farm, street, factory, office	Yes 2 No	28f Location (St	treet and Number or Ru	ural Route Number
Division of Vital Records,	after c	Certification:	4 Homicide determined	building, etc. (Specify)			City or Town		, torriday
-	or no rospinal or Autending Friysicans: To the Turneral Directors After this certifica completely filled in by the funeral director,	edical Co	29a. Certifier 1 Certifying Ph (check only one) 2 Medical Exam	ysician: To the best of my know niner: On the basis of examinati and manner stated.	viedge, death occurred at the	e time, date and place by opinion, death occ	I e, and due to the c urred at the time, d	ause(s) and manner as	stated. e to the cause(s)
4	ithin (Med	29b. Signature and title of certifier	and mariner states.	29c. Lice	nse number	25	9d. Date signed (Month	ı, Day, Year)
, F	= ≱ ⊭ ŏ		Auge .	, M.D.	RE	S-000		7/2/08	
	1		30. Name an laddress of person who	completed cause of death (Item	1 23a) (Type, Print)				-
	3	W. 1	ANGEL CHAN			600	North Wol	fe St, Baltimo	re, MD, 21287

State Registrar

ANGEL CHAN 31. Date filed (Month, Day, Year) JUL 0 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21744 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Marie Tellis July 4, 2008 5:30 pm^N /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1126 Engleberth Road Essex Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min Director 215-07-9062 89 3/26/1919 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, It e Medical Exp. :it at must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f shout the Medical Exp. in er must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1126 Engleberth Road 21221 S. A. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No \$ Specify. 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U. S. Army College (1-4or 5+) Elementary/Secondary (0-12) Statistical Clerk Corp of Engineers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Ziemann Ethel McCallister 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once. Linda Neubauer (Daughter) 1123 Engleberth Road Essex. Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/9 2008 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. Baltimore, Maryland 22. Name and Address of Facility BRuzdzinski Funeral Home PA 1407 Old Eastern Avenue Ess 21. Signature of Funeral Service Licensee Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Metas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of requires that the death certificate be executed ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter for u in the past 12 months? 3 Ectopic pregnancy Month Day signed by the a 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by s been si should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has page 2 autopsy performed of Vital 1 ☐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Medical 1 X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058475

State Registrar

DHMH 17 Rev 1/2001

PHELEP

31. Date filed (Month, Day, Year)

0 7 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHYSZCIAN

NIVATPUNIN, 602 SOUTH ATWOOD ROAD, BELAIR, MD 21014

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Frank J. Trovato **Physician** July 3, 2008 8:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Baltimore Catonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 X M 2 □ F Date of Birth (Month, Day, Year) **Funeral** Days Hours Feb. 24, 1915 93 Director 082-10-7049 New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e 715 Maiden Choice Ln, Apt. CR511 21228 "natural", or items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1943 If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. nit, Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or ite injury or other traumatic event, the Medical Examines 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: <u>م</u> 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry oa. Decedents o Susui Occupation
(Give kind of work done during most of working
(life, PO NOT use retired)

Quality Assurance/
Procurement Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antonino Trovato Carmela Scattareggia 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank A. Trovato - Son 21 South Stricker Street, Baltimore, MD 21223 20b. Place of Disposition (Name of Scametery, cremetory or other place) Ta Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 X Removal from State Pinelawn Cemetery 5 ☐ Other (Specify) 4 Donation 7-8-2008 Pinelawn, New York 22. Name and Address of Facility Ambrose Funeral Home, Inc. Funeral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: iin 24 hours after death. the Funeral Director; After this certifica pletely filled in by the funeral director, p To the Hospital o within 24 hours aft To the Funeral Di

5 Pending investigation 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

en Chouce Can

31. Date filed (Month, Day, Year)

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vall

Registrar's Signature

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21746

iam Thompso		- Fo	or State	Sta	ate or	Mai yiai i	Ce Ce	ertifica	te of	Death	•				Reg. No.			3. Time of De	oth
hysicia	E	3	strar ecedent's Name	(First, Middl	le,Last)								1	Date of De Month	Day	Year	.	2120 hrs	- I
xamiı	ner		Merian	n E. !	Thom	pson								July 1, 2		. County o	f Death		
		4a. l	Facility Name (i	f not institution	on, give str	eet and num	ber)		41	b. City, To Baltime		cation of L	Jean						
		. 1	Maryland G	eneral Ho	spital							If I Inder	24Hrs	8. Date of	Birth (MM	/DD/YYYY	9. Birt	hplace (State	or
Funeral		5. S	Social Security Number 6. Sex 7. Age (In yrs. last birtiday)								06/25/1944			Foreign Country) NC					
Director	ŀ	14	49-36 -	2089	1M	2 x F		64	Yrs.					06/2	25/1	944	<u> </u>		
	n		ual Residence o	f Decedent			1100 0	city, Town	or Locatio	on								10d. Inside (
any		10a	a. State	10b. County	'													1 Yes	2 No
nd show ace,	'n		MD na Baltimore 10f. Zip Code								10g. Ci	tizen of Wi	nat Cou	ntry?					
Aaryland 28a-f show 1 at once,	Director	10e	Street and Number 01 McMechen Street Apt. 304					304	21217						τ	ISA			1
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MD 21 and 2 should lealth and Me tem 27 is ma traumatic es	ļ	1	Wendy	Brya	nt-D	aught	er	20b. Place	of Dispo	San esition (Na	ne of cer	metery.	ve.	Date	20	c. Location	ı - City o	or Town, State	•
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	<u> </u>		UNPENDED AMENDED																
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Vis or A after Dire	dinb	Ĭ	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) dwelling 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street or Town, State) 289 Rockrose A								e Ave, Ba	e) Ave, Baltimore , MD							
Divisior Hospital or Attend 24 hours after death Funeral Director:	fille	ë	4 Homici			117			death o	ccurred at	the time	, date and	place, a	and due to	the cause	(s) and ma	inner as	s stated.	
he Ho In 24 l	pletely	g	29a. Certifier 1 (Check only one)	✓ Medica	ng Pnysic I Examine	r:On the bas	sis of examin	nation and	/or inves	tigation, ir	my opin	nion, death	occurre	ed at the tin	ne, date a		_		(S)
To the within To the	com	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and under the control of the basis of examination and/or investigation, in my opinion, death occurred at and manner stated. 29b. Signature and title of certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and under the control of my pl									29d. Date signed (Month, Day, Fear)			,Year)				
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67			30. Name and	address of -	erson who	completed	ause of d	at (Item 2	(3a)	w									
2		-1		address of p re M. King			stant Me	edical Ex	amine	r 111	Penn	Street,	Baltim	ore, MD	21201				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 4, **Physician** 2008 4:25 А м Anna A. Testani /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkville Oak Crest Care Center 8. Date of Birth 2-27-1922 rthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☑ F 85 218-18-4520 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore Parkville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21234 USA 8820 Walther Blvd Apt # 2414 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nazarana Carminucci John DeAngelis ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Army Road Towson, Maryland 21204 Maryann Kelly / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/7/2008 Timonium, Maryland Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21204 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1□ Yes 2 2 No certificate | director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pas (cuille M1) 21234 Boulesand 8800 walther Anna Monius 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 21748 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death **Physician** PM Inomas /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ltimore Social Security Number Date of Birth (Month, Day, Year) G-25-3 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be mentally once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MdTIMOVE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☒ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Bennie ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherie Collett Elkridge, Daughter 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Euneral Serv. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appro imate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 11 Ca /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of the burial-transit signed by the attending physician and deetached for use as the burial-trar Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐ Yes 2 □No 1 □Yes 2 **N**No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death. To the Funeral Director: After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day,

Vivian Themas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signature

Year)

0

29c. License number

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 30, **Physician** 2008 Edward William Tatge 8:38 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9707 Old Georgetown Road, #2309 Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 356-24-4035 Director 82 1926 Illinois May 30, Usual Residence of Decedent Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Bethesda the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2; any Injury or other traumatic event, the Medical Evantage. 9707 Old Georgetown Road, #2309 20817 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ⊠ Yes 2 □ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 Married WWII 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Internationalist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward George Tatge Marion Szymanski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gigliola Tatge / Wife 9707 Old Georgetown Rd., #2309, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. July 5, 2008 Bethesda, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service V censee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepatocellular Carcinoma 1.5 Years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hepatitis C > 30 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed bunial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dev 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has the autopsy performed? 2

No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) To Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation After 1 X Natural e Hospina. —
n 24 hours after death.
the Funeral Director; After a funeral by the funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral f 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: 2 Medical Examiner: Of 29a. Certifier 76 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifier MD.09238R 08 DI 2041 MD 20892-1800 30. Name and address of person who completed cause of death (Item 239) (Type, Print) Bethesda, 10 Center Dr. Marc Ghany, M.D., NIH-Liver Diséase Branch, Bldg. 10, Room 9B-16, 31. Date filed (Month, Day, Year) 32. Registrar's Signa State 2008 Registrar 7

			for State Registrar	State of Mai	ryiand / Depa <i>Cei</i>	rtment of F tificate of		lental Hygi Re	ene 200	8 21750			
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/Medical Examiner			4a. Facility Name (If not institution, give		1 (117)	4b. City, Town, or Location of Death			31 Ye.				
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	Funeral Director		5. Social Security Number 6. S 216–44–8921	Sex 7. Age M 2 F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)			
			Usual Residence of Decedent										
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	the M		10e. Street and Number	ilde1	Lagewa	10f. Zip Code			1 ☐ Yes 2 No 10g. Citizen of What Country?				
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	ter death with the Marylan items 23a or 28a-f show itter must be notified at	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13. V		lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian,			
936	72 hours after death with the Maryland "natural", or items 23a or 28a-f show disal Expresser must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:		□Yes 2XNo	Specify:		Specify: white				
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/lan			William John Wal	smith		•	Ruth Pea	arson	n				
lar,	2 sho and l is me		19a. Informant's Name/Relationship (19b. Mailin	g Address (Street	and Number or Rura	ral Route Number, City or Town, State, Zip Code)					
	1 and Health em 27 ther to		Shiela Walsmith/s	pouse			re Edgewat		21037	ov Town Chate			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menti Important: If item 27 is marked any Injury or other traumatic e once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specif		20b. Place of Dispos cemetery, crem	atory or other plac	e)	ate 2	0c. Location - City	or rown, State			
Bal	permit Depar Impor any In	l l	21. Signature of Furer Service icer	Wade, Vire		Name and Address ate Anato ltimore.	omy Board MD 2120		Baltimore	Street			
			23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate C use (Final disease or condition a. a. a. a. a. a. a. a. a. a. a. a. a.										
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05^{ay} **Physician** 2008^{ar} July 0'D. Eugene Winand 2:27 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1934 1 X M 2 □ F Mary land 212-30-3258 74 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Modical Expandrational by rutified 21 appear. Director Md. Baltimore Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1844 Glen Ridge Rd. 21234 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balt. County Schools Site Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kirby O'Dunne John Ρ. Winand ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1844 Glen Ridge Rd. Baltimore, Md. 21234 Mrs. Sandra Winand/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Co. 7-7-08 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fundal Savice Livens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END-STAGE LIVER DISFASE **Physician** /Medical **Examiner** HOLANGITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consegu To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Inector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Septicemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XN0 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date sigped (Month, Day, Year) of death (Item 23a) (Type, Print) BaltoMD 21204 TOWSONTOWN BLUD 31. Date filed (Month, Day Year) 008 32. Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July **Physician** ^{Day}008 3, Carolyn Workman 12:00 aM Esther /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Ruxton Ruxton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Jan 20, 7906 Months Days Hours Min. West Wirginia 236-54-2523 102 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Timonium 1 □Yes 2XINo Director 10e. Street and Number 10f. Zip Code 21 093 10g. Citizen of What Country? 2453 Springlake Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Specify þ Specify: 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emory Duffield Fmma Cadle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Workman-son 2453 Springlake Dr., Timonium, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)

Tyler Mt. Memory Gar. 7/7/08 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cross Lanes, WV 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee William 22. Name and Address of Facility Ruck Towson Funeral Home, G. Dau 211 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** andstag reass /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) No 1 ☐ Yes ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760 Records, P.O. Division or Vital JORKANAN the Hospital or Attending within 24 hours after death To the Funeral Director:

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

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signed by

page 2

certificate !

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Maryland 21215-0036

Baltimore,

filled in by

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, 1

29c. License number

29d. Date signed (Month, Day, Year)

death (Item 23a) (Type, Print)

and manner stated.

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State Registrar

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faryla i sho	l		10c. City, Town	or Location				10d. Inside City Limits 1 □ Yes 2 ☒ No
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after or ite	1		0	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Rican, etc.)	Black	x, White, etc.
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Exercite trains the notified a		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	20b. Place of I	Disposition (Name of crematory or other place	ce)	Date 2		City or Town, State
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State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 5:45 P M 2008 Helen Aiken June /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Health & Rehab Center Anne Arundel Co. Glen Burnie Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct. 5, 1922 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 1 □ M 2 🕅 F Months Days Hours 450-26-6271 85 Oct. Texas Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28e-f show traumatic event, Its Madical Examiner must be notified at Maryland Anne Arundel Baltimore 1 ☐ Yes 2XXVIo Completed by Funeral Director 10e. Street and Number 13 Pebble Drive 10f. Zip Code 10g. Citizen of What Country? 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 227No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes ŽXNo Specify: Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) Bookkeeper Produce Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Arthur Magee Alberta Valliant Pages 1 and 2 should by ment of Health and Menta ant: If item 27 Is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwynn Frock/daughter 13 Pebble Drive Baltimore, Maryland 21225 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Laurel Land Mem. Park 6/23/2008 Dallas, Texas 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of unera Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Cloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PRIMARY HEPATUCELLULAR CARCINOMA disease or condition resulting in death) /Medical Examiner THE LIVER. CIRRHOSIS 07 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 12 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OSTEOARTHRITIS OF THE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown HIPS. 24b. Were autopsy findings available prior to completion of cause of death?
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Funeral Director: After the letely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a cal 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/10/2008 17753 more no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3721 POTER St. BALTIMORE, MD 21225. DHARMASTONA, M.O. 32. A gistrar's Signature 31. Date filed (Month Year) JUN 1 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Thelma Emma Alder June 16, 2008 58 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Tate Chesapeake Hospice House Linthicum If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□ M 2 T Months Days Hours Min 83 Nov. 20,1924 Maryland Director 218-22-6053 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No MD Annapolis Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23a or: 933 Edgewood Road , Apt. 105 21403 USA Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify White Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Me lical Elementary/Secondary (0-12) College (1-4or 5+) Chief Accounting Clerk Railroad 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll B. Lang Mildred E. Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol Anne Elton/ Daughter 478 Riverside Drive Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or of once. June 18, 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, Maryland Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** paura /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): aftending physician the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 2 No 2**/2** No 1 ☐ Yes To the Hospital to proceed within 24 hours after death. To the Funeral Director: After this certified proceed with the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSpice House 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural June 1, 2008 UNK M 1 1 28e. Place injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 🕅 No tall in Dathroom 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 4 Homicide Longe CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Monti

JUN 1 9 2008

DHMH 17 Rev 1/2001

istrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	1.	For State Registrar Decedent's Name (First, Middle, Last)		-	tificate of l		2. Date of De	Reg. No.	2008	2 7 3. Time of Death
sician ledical	1	William Marion Al					June	18, Day		1:15A.
miner	4a	. Facility Name (If not institution, give stre Laurel Regional Hos	et and number) $\operatorname{\mathtt{pital}}$		Laurel	Location of Death				George's
eral ctor	L	327 0, ,200	7. Age (In yrs. I	ast birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct. 3)	1955	Cour	place (State or Fore ptry) ington, D
ned at	10	na. State 10b. County Maryland Prince Geo		y, Town or Lo	cation				1	10d. Inside City Lim 1 X Yes 2 ☐
nner must be nounted Funeral Director		ne. Street and Number 12113 Tanglewood La	ne		10f. Zip Code 20715			10g. Citize Uni	en of What Coul ted Sta	ntry? tes
any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11	. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
t, the Medical E	-	(Specify only highest grade co	ion ompleted) College (1-4or 5+)	16a. Deced (Give life. Roofe)		pation during most of work d)	ing	ĵ.	d of Business/In	-
atic event, til To Be Co	1	7. Father's Name (<i>First, Middle, Last)</i> William Marion Albr	right, Sr.	<u>L</u>		18. Mother's Nam Edna Mae			Burname)	
r traumati		9a. Informant's Name/Relationship (Type. Connie Y. Albright		19b. Mailii 1211.	ng Address (Street 3 Tanglwo	and Number or Rui ood Lane I	Bowie, l	oer, City or Maryl	Town, State, Zi, and 207	15
ury or other	21	Da. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	noval from State 20b. F	Place of Disponentery, creating tropol	osition (Name of matory or other place itan Cren	ce) natory 6/1	Date 19/2008		ation - City or T andria,	
any inj	2	1. Signature of Funeral Service Licenses	gwart	_ B	onaladddd 400 Powde	Borgwardt er Mill Ro	t Funer oad Bel	al Ho tsvil	me, PA le, Mar	yland 20
burial-transit au legi	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minimidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End Stage Liver Disease Due to (or as a consequence of): Cirrhosis of Liver Due to (or as a consequence of): Due to (or as a consequence of):									
completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Medical Certification: To Be Completed by Physician/Medical Examir	1 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of α 9 □ Unknown	aldeath 3	□Ectopic pregnand □ Other (specify) _	sy		2	3d. Date of deli Month	very Day Year
d be deta	٠١.	art II. Other significant conditions control Acute Renal Failure			underlying cause gi	ven in Part I.			se contribute to ☐ No 3 ☐ Pro	the cause of death bably 4 Xunkn
completed	. -						per 1∐ Yes	opsy formed? 2 2 No	24b. Were au prior to death? 1 ☐ Yes	topsy findings avail completion of cause 2 🛣 No
funeral director	-	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ X No 1 ☐ X Natural 5 ☐ Pending investigation	spital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c. Inju			sidence (5 ☐Other (Spec y occurred	cify)
led in by the funer Certification:		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci				City or T	own, State		ral Route Number,
ompletely fill.		29a. Certifier 1 X Certifying Physic (Check only one) 1 2 Medical Examine	clan: To the best of my kn er: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occi	e, and due to thurred at the tim	e, date and	I place, and due	to the cause(s)
Me		29b. Signature and title of dertifier	-	MO	100	1 6 4 9 8 6			te signed (Monta	h, Day, Year)
8		1			- 00					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Hont 30-2008 **Physician** 5:10 A Anwar Ali /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-21-1949 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min 112-82-5753 1**X** M 2 □ F 58 Trinidad Tobago Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10h County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantinar must be notified at once. 1 ☐Yes 2 No MD Frederick Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Trinidad Tobago 21703 4864 McLauren Court **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Revasat Ali ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4864 McLauren Court Frederick, MD 21703 Ali Wife Hazra 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-1-2008 Mount Olivet Cem. Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. MO1176 106 East Church St. Frederick, MD 21701 23a. Part 1. Phter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Liver Disease Physician /Medical Due to (or as a consequence of): **Examiner** Variceal Bleeding Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 🔲 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an s certificate has be lirector, page 2 sl autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2 No Certification: To 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: / 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

31. Date filed (Month, Day, Year) **JUL 0 7 2008** DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who complete

Juanita L. Smith M.D. 9901 Medical Center Drive Rockville, MD 20850

and manner stated.

completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of a			ene g. No. 🤈 (ากฉ	21759
Di			1. Decedent's Name (First, Middle, La	st)				2. Date of Death	Day	Year	3. Time of Death
	ysicia Aedic		Mary Elsie Brown					June 16,		real	6:35 p
~	amin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	r Location of Deat	h	4c. Count	ty of Death	-
			Somerford Place			Annapoli	is	I	nne Arı	ındel	
Fun	eral		5. Social Security Number 6. S		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.				lace (State or Foreign
Direc	ctor		578-34-0701	□ M 2 KO KF 94	Yrs.	World Days	Tiours Willi.	May 30, 1		Mary	
P.			Usual Residence of Decedent								
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± 50 €	2	ie	10e. Street end Number			10f. Zip Code		10	g. Citizen of	What Coun	try?
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U Z I Z I S-UUSO filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show	9	ne.	11. Marital Status	12. Was Decedent B Armed Forces?		Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Ra	ace - Americ	
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Z I Z I D-UUSO d within 72 hours aff glene. er than "natural", or	100	je	15. Decedent's Ec (Specify only highest gra	lucation	16a. Deced	lent's Usual Occup	ation	lein =	6b. Kind of B	Business/Inc	dustry
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partitions, Mai yiallo 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show	vent,	Se C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M			
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nd 2 should be file lith and Mental Hy 27 Is marked oth	rmar l		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street		ural Route Number,		n, State, Zip	Code)
ING 2 III a 27 Is	Tra		John Puglise/Son		907 Gunni	son Court,	Gambrills	, MD 21054			
te Hear	te		20a. Method of Disposition		20b. Place of Dispos	sition (Name of	1		Oc. Location	- City or To	wn, State
ages C	١٥		to Burial 2 ☐ Cremation 3 ☐		1	natory or other place	Jun	e 20,			
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Dallinore, permit. Pages 1 au Department of Hez Important: If tem	DC6		21. Signature of Funeral Service Cel	see	Fr	. Name end Addre	ollins Fun	eral Home I	nc.		
- 40-			1 John / X	4				, Silver Sp		D 20901	
Physic	_		23a Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin Advanced	e.	er the mode of dyir	ng, such as cardia	c or respiratory arre	ST,		Approximate Interval Between Onset and Death 10 Years
/Medi Exami	_		resulting in death)	Due to (or es a	a consequence of);						
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ficate be executed physician and	e	dical		d							
	as .	ĕ l	IF FEMALE:								_
death certifi	sn l	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		Ectopic pregnanc	v			ate of delive	
. 0 07	o pe	<u>S</u>	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown		Other (specify) _	,		_ N	1onth	Day Year
at the de	lache	ڇَ	9 Unknown	9 LI CIRIOWII							_
_ ~ ~ ~	e 0e	by P	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the ur	derlying cause give	en in Part I.	23e. Did tob	acco use cor	ntribute to th	ne cause of death?
quire an siç								1 ☐ Ye	s 2 🗷 No	3☐ Prob	ably 4 🗌 Unknown
w re species	ous .	Completed						24a. Was an	24b	. Were auto	psy findings available
he lav	bage	Ĕ						autopsy perform	ed?	prior to cor death?	mpletion of cause of
Iclan: The certificate	, pg		25 Was assa referred to medical					1 ☐ Yes 2		1 □ Yes	2 □No
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To the Hose within 24 ho	ed	Medical	one)	and manner sta							
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10			· w/m/	17/9	ms I'll		D46360		June	18, 20	08
			30. Name and address of person who	· ·	, , , , , ,	*			-		
			Michael Ankrom, MD		ran's Highway	, Millersvi	lle, MD 21	108			
	Stat	е	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	adas					
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DHMH 17 Rev 1/2001

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la. Facility Name (If				JASHINGT		ty, Town, or		of Death			ounty of Death	RY	
5. Social Security N 119-30-2		6. Sex 1 ☐ M 2 🛣		(In yrs. last birth	nday) if Und Month	der 1 Year Is Days	if Under Hours	24 Hrs. Min.	8. Date of Bir	th 1914	9. Birth	olace (Sta OLANI	te or Foreig D
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0e. Street and Nur	mber				10f.	Zip Code				10g. Citizer	n of What Cou	ntry?	
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	12			HC	MEMAKI	ER .				1	N HOME		
17. Father's Name ((First, Middle,	Last)					18. Moth	er's Name	(First, Middle	, Maiden Su	ırname)		
MOISHE	CHAIM	HODES							SONDIK		-		_
19a. Informant's Na MARTIN BF)						l Route Numb ROCKVIL		own, State, Zij 20853	o Code)	
0a. Method of Disp 1 XBurial 2 [4 Donation	☐ Cremation	3 ∑ emoval f	from State	20b. Place of I cemetery HOUSE C	, crematory o	or other plac			ate 19/200		tion - City or T ITESBOR		
21. Signature of Fu					22. Name	and Addres		-	L DIRE	CTION	FINC 20	852	
Sequentially list co if any, leading to in cause (Disease or that initiated events resulting in death) L	3	S	hype	consequence of	ion	eng '	dis	ese				20	year
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ⊡ 9 ☐ Unknown	months?	1 □ L 4 □ F		of pregnancy 2 ☐ Fetal death ime of death	3□Ectopi 5□ Other	c pregnancy (specify)				230	d. Date of deliv	very Day	Year
Part II. Other signif	ficant conditi	ions contributing		t not resulting in	the underlyin	g cause giv	en in Part	l.		tobacco use	e contribute to No 3 ☐ Pro	the cause	
									24a. Was auto perf 1□ Yes		24b. Were aut prior to co death? 1 □ Yes	opsy findiompletion	ngs availa of cause
25. Was case refer examiner?	,	Unanital				DOA Oth		<u> </u>	(Check only				
1 ☐ Yes 2 🗹	th 5	28a. I	1 ☐ Inpatien Date of Injury (Month, Day	/ 28b. T	ime of ijury	28c. Injur Wor	y at k?		me 5 ∐ Res 28d. Describe		Other (Specoccurred	ify)	
	invest	igation	Place of inju	ry - At home, fan (Specify)	m, street, fac		Yes 2		28f. Location City or To	(Street and a wn, State)	Number or Ru	ral Route	Number,
27. Manger of Deat	6 ☐ Could detern	not be nined 28e. I	bullding, etc										
27. Manner of Deat 1 Matural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could detern	ing Physician: T	To the best o	examination and	death occur dor investiga	red at the til tion, in my o	ne, date a pinion, de	ind place, eath occuri	and due to the red at the time	e cause(s) a e, date and p	nd manner as place, and due	stated. to the cau	ıse(s)
27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only one)	6 Could detern	ing Physician: T	To the best of	examination and	d/or investiga	tion, in my o	pinion, de e number	and place, eath occurr	red at the time	29d. Date	signed (Month	to the cau	ar)
27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only one)	6 Could detern	ing Physician: T i Examiner: On and	To the best of the basis of I manner stat	examination and	d/or investiga	tion, in my o	pinion, de e number	eath occurr	red at the time	29d. Date	signed (Month	to the cau	ar)
77. Manper of Deat 1 Matural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	6 Could detern	ing Physician: T i Examiner: On and	To the best of the basis of I manner stat	examination and	d/or investiga	tion, in my o	pinion, de e number	64	red at the time	29d. Date	place, and due	to the cau	ar)

State Registrar

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Date of death 6/14/08

Belle Brodey Dob 2/5/14 Division or Vital Records, P.O. Box 68760,

12:50 pm

			For State	State o	of Maryla		artmer <i>rtifica</i> :		ealth and N	Mental Hy	•		
			Registrar 1. Decedent's Name (First, Middle, La	est)		Ce	runca	e or L	Jeain	2. Date of De	Reg. No.	2008	3. 2 J 7 6 0
	Physici		Hattie Mae Barbo							Month June	Day	Year	12:40 A M
	/Medio Examin		4a. Facility Name (If not institution, gir		ımber)		4b. City	Town, or	Location of Death	June .		County of Death	12.40 A
			Shady Grove Adve	entist 1	Hospita	1	Ro	ckvi]	lle			Montgom	ery
	Funeral		Social Security Number 6. 9	Sex I□M 2□xF		s. last birthday)	If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Cou	
10	Director		5/8-66-2115	I L IVI Z L	59	Yrs.				Jan. 2	8, 19	49 Wash	ington, DC
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation						10d. Inside City Limits
	Mary f sh	φ	MD Montgo	n o r 37		Gaithe	rchu	ra					1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number	псту		Garcine		p Code			10g. Citi	zen of What Cou	ntry?
	h with	a D	66 Anna Court					2087	77		Un	ited St	ates
	deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Dece		spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or N		14. Race - Ameri	can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lury or other traumatic event, it. Modical Exacting content to inclified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ∐Yes If Yes, G Year or [2 XNo ive		1 □Yes		Specify:	rnoan, etc.)		Black, White, Specify: B	lack
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece			ation Juring most of work	ina	16b. Kii	nd of Business/Ir	ndustry
7	thin 7	nple	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT	ise retired)	uning most of work	ang			
7	ed wi ygier her th	ပ္ပ	12	2		Mar	nager					tomotiv	е
ב	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam			Surname)	
3	d Mer narke	ဥ	Albert McLean			1				Colbe			
a Z	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship			1	•	,	and Number or Ru				p Code)
Baltimore, Maryland	1 and Heal Heal Sem 2		Val Scannel (Fr: 20a. Method of Disposition	Lend)	20b.				Gaither	sburg, Date		20877 cation - City or T	own. State
<u>0</u>	ages ent of t: If it	- 1	1 ☐ Burial 2 ☑ Cremation 3 ☐		State	Place of Dispo			June	17,		•	
≣	artme ortan Injur		4 □ Donation 5 □ Other Special 21. Signature of Funeral Service lice		Me	tropol:	Ltan 2. Name a	Crem.				andria,	VA.
ñ	Dep Jany any		De Aller	TA and					50	Vol Fu			MD. 20877
			23a. Part 1. Anter to disease, or com	plications that	caused the dea							isburg,	Approximate
	Physician	4	shock, or heart failure. List only Imme to the Ause (First) disease condition	one cause on		PIRATOI	1 —	(-A	LURE				Interval Between Onset and Death
	/Medical		resulting in death)	a Due to	(or as a conse		U-1	PAI	COICE			-	
	Examiner			b		NEUMON	VIA						
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enner Underlying Cause (Disease or injury	Due to	(or as a conse		-		2020 9100			· ·	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			ic i	UNC	CANCEL	2			
Ő,	be ex cian a surfal-		resulting in death) Last	Due to	(or as a conse	equence of):							
68760,	ifficate be executed g physician and as the burial-transit	edical	•	d									
		/Me	IF FEMALE:	23c. If ves. or	tcome of preg	nancy						and Data of data	
POX	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	birth 2☐Fe	tal death 3[☐ Ectopic☐ Other (s		•		1	23d. Date of delive Month	/ery Day Year
j.	at the de by the stached	ysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9 ☐ Unk		, 1040.	_ Othor (c	peony/					
٠ <u>٠</u>	de d	by Pł	Part II. Other significant conditions	contributing to c	leath but not re	esulting in the u	nderlying	cause give	n in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ğ	quires an sign uld be									1 🗆	Yes 2[□ No 3□ Pro	bably 4 🔀 Unknown
ပ္တ	s been se should I	Completed								24a. Wa		24b. Were aut	opsy findings available
ř	The law ite has age 2 s	E						-		perl	opsy ormed?	death?	ompletion of cause of
<u> </u>	lan: rtifica stor, p	BeC	25. Was case referred to medical						26. Place of Dea		2 No	1 □Yes	2 LIN0
<u>-</u>	Physician: The la this certificate ha ral director, page 2	70 E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1X	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 D	OA Othe	er: 4 🗆 Nursing H	ome 5□Res	sidence (6 ☐Other (Spec	ify)
0	ding Ph h. After thi funeral	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day, Year)	28b. Time o Injury	f	28c. Injury Work	at at	28d. Describe			
<u> </u>	ttendi death. tor: A the fu	cati	2 ☐ Accident investigation				М	1 🗆 \	/es 2□No				
Division of Vital Records,	or Attendater death Olrector: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	20e. Place	e of Injury - At ling, etc. <i>(Sp</i> e	home, farm, str cify)	eet, factor	y, office			(Street an wn, State		ral Route Number,
_	pital.		20a Cartifica		- h 1	- 1 - 1	l	1 - 1 - 2		2			
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeal Director. After this certifics completely filled in by the funeral director, p.	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	miner: On the	basis of exami				ne, date and place pinion, death occu				
	To the within 2 To the comple	Mec	29b. Signature and title of certifier		nner stated.		29	c. License	number		29d. Dat	te signed (Month	, Day, Year)
•	F 3 F 8		> Ollexender	N	lulam			006				15/08	
•			30. Name and address of person who						· · · · · · · · · · · · · · · · · · ·		- 1	- / 55	
			Alexander MulaM	ıla M.D	. 9901	Medica:	l Cen	ter I	Orive Roo	kville	, MD.	20850	
	Sta	te	31. Date filed (Month Day Y2")0	2000 32.	egistrar's Sign	nature	1						
	Registr	ar	JUN N U	LUU0 A	108162	15. 6	DEAGE	1					

08-05025		Please Type or Print in Black Indelible Ink. Ensure All Copie	s Are Legib		
Michael D. Bering		State of Maryland / Department of Health and Mental Hy	/giene	200	8 2176
	R	- For State Certificate of Death	Reg. N	lo.	Time of Death
Physicia	1/	i. Decedent's Name (First, Middle, Last)	2. Date of Death Month Da	y Year	1826 hrs
Medical Examin		Michael David Derenger.	June 29, 200	4c. County of Death	
The state of the s	•	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore		are, obtains or bottin	
,		Occident and the second of the	8. Date of Birth (M	MM/DD/YYYY) 9. Birthr	lace (State or
Funeral	- ['	Months Days Hours Min.		Foreign Cour	Baltimore,
Director	L	620 - 62-4011 1 XIM 2 F 49 Yrs.	2/25/	119591 000	"" MI
>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
w an		The state of the s			Yes 2 No
fand f sho	흐	1.0	10g.	Citizen of What Countr	y?
Mary Fr 28a	Director	OLD 2.4		115 A	
ath with the Maryland items 23a or 28a-f show is be notified at once.	잁	TOAL FIAN ORS NO. TIP.	necify Yes or No-	14. Race - America	n Indian, Black,
th wi	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	,
er dea	ᇍ	Never married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:		Specify: Wh	ite.
rs aft uraf"	솔	15 Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of	work done 16	b. Kind of Business/Inc	
2 hou	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	ired)	1	
36 bin 7 e. than	흵	12 2 Technical Supp	port	Comeast	•
5-0036 led within 7 Hygiene. other than	하	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Mai	den Surname)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Be	Louis T. Berenger Dori:		mann	
2121: ould be fil I Mental I s marked	리	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	A		Zip Code)
MD d 2 sh lth and n 27 is		Danielle Steed man-daughter-11027 Lynch Rd. 1	Saltimor	E ML > Oc. Location - City or T	Own State
Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State	Date 2	OC. LOCATION - City Of 1	own, olate
no pages ages of nut: 1		Wasaland Warm Fock I'll	3 08	BALTIMOR	E MD.
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the MES.	- 1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	OHARFORD	MD. BALTIA	10 RE, MD 2123
S F F F F F	1	LIMITALL MAINTELL EVANSFINAMICHARA	12 (xomatic	on Seevices	- Parkuille
Physician	T	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arrest	, snock, or neaπ	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Pulmonary thromboembolism			Death
ammer .	- 1	or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
	Ë	cause. Enter Underlying Cause			
175.	Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
xecuted n and l - transit	calE	X AMENDED #1 as noted, 23a,27,perME, g8	82 8/7/08	77	
	g	X UNPENDED X AMENDED #1 as noted, 23a,27, perme, go	02 0/7/00		
68760, certificate be nding physicise as the buri	an/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregr	ancv	23d. Date of delivery Month D	ay Year
68° certiff se as		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	arioy		,
Box e death o the atten ed for us	Physic	1 Yes 2 No 9 Unknown 9 Unknown			
O. E at the d by the etached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
ords, P.O. Bo w requires that the de as been signed by the should be detached fi	by		1 Yes	2 No 3 Prob	abiy 4 V Unknown
Records, The law require ficate has been si, page 2 should b	Completed		24a. Was ar		topsy findings available ompletion of cause of
COT law r has b	du		perform 1 ✓ Yes 2	ned? death?	
tal Rection: The certificate	Ş	25. Was case referred to medical 26.Place of Death (Chec	1.50		
of Vital ng Physician: After this certi	Be	23. Was case referred to friedross		esidence 6 Other	:
n of Vit ding Physic After this	ဥ	1 ✓ Yes 2 No The Injury 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
ding h. After	Certification:	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
IVISION OR Attendance death Director:	cati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.			ral Route Number, City
Division tall or Attendit rs after death.	III	Suicide Could not be determined (Specify)	or Town, Sta	ate)	
Di ospital bours a uneral I		29a. Certifier . 2	nd due to the cause	(s) and manner as stat	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be eximitin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burnal	ical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrent	d at the time, date a	nd place, and due to the	e cause(s)
To Com	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
	-	O.C.M.E.		June 30, 2008	!
		30. Name and address of person who completed cause of death (Item 23a)			
		Zahiullah Ali M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
	tata				
S	tate	31. Date filed (Month, Day, Year) 31. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

Hospital or Attending

after death. filled in by 24 hours a Funeral I

completely To the I within 2

> State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

(30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elba J. Martinez,

29c. License number D06959

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

6/17/08

and manner stated.

M.D. 8808 Hidden Hill Lane, Potomac, MD 20854

32. Registrar's Signature

	pe	
	ne Hospital or Attending Physician: The law requires that the death certificate be executed no.24 hours after death.	ne Funeral Director: After this certificate has been signed by the attending physician and
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	ne Hospital or Attending n 24 hours after death.	era
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			For		State	of Mary	•	artment of F			lental Hy	_				
			State Registrar				Ce	rtificate of	Deatl	h ,		Reg. No.	200		17	63
	Physicia	an	Decedent's Name (First, M.								2. Date of De Month	Day		ar	7 • 7 5	Death 5 aM
	/Medic		4a. Facility Name (If not instit		ryette S		elbaum	4b. City, Town, o	r Location	n of Death	June	19	County of D			aivi
	Examin	er	Casey House - M			-			ockvi					itgomei	rv	
	Funeral		5. Social Security Number	6. Se			yrs. last birthday	if Under 1 Year	If Unde	er 24 Hrs.	8. Date of Bi	rth		Birthplace	-	Foreign
	Director		577-36-3308	11	□ M 2 2 F		78 Yrs.	Months Days	Hours	Min.	July 2		9 Dis	Country)	of Co	olumbia
P	>		Usual Residence of Decedent 10a. State 10b. Co.			100	c. Cify, Town or L	ocation						10d Ir	nside City	/ Limits
laryla	shov	2			D t-	100	2. Ony, 10mil 01 E		- n						Yes:	
the	28a-f	Director	Florida 10e. Street and Number	raim	Beach			10f. Zip Code	a Rat	on		10g. Citizen of What Country?				
with	3a or it be	Ö	5353 Steep	a Cha	eo.				334	96		3	п	S.A.		
death	ms 2	Funeral	11. Maritai Status	ie ona	12. Was De	cedent Ever	in U.S. 13.	Was Decedent of H			ecify Yes or N	0-	14. Race - A	merican In	idian,	
after	or ite	Ē	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No Specify: 1 □ Yes 2 ☑ No Specify:								Hicari, etc.)			/hite, etc.		
S Ino	Exa	d by	3 ☐ Widowed 4 ☐ Divo	rced	Year or					.,,.			Specify:		ucasi	an
5 2	"natt	Completed	15. Dece (Specify only h	edent's Ed ighest gra		")	(Give	edent's Usual Occup e kind of work done DO NOT use retire	durina m	ost of work	ing	16b. Ki	ind of Busine	ess/industr	ý	
with 1	than	dmo	Elementary/Secondary (0-	12)	College	(1-4or 5+)	iiie.	Analys					Federa	al Gove	ernmei	nt
E P	Hygir offher ant, th		17. Father's Name (First, Mid	idle, Last)	4	-		maiya		ther's Name	e (First, Middle	e, Maiden		11 001	Timei	
d be	ked c	To Be	Micl	nael J	. Schwar	tz					Ber	tha Ra	aban			ļ
Shou	and M s mar umat		19a. Informant's Name/Rela	tionship (7	Type. Print)		19b. Mail	ing Address (Street	and Nun	nber or Rur	al Route Num	ber, City o	r Town, Sta	te, Zip Coa	le)	
and 2	alth a		Dr. Robert Dec	kelba	um - Hus	band	535	3 Steeple C	hase,	Boca	Raton, F	lorida	33496			
S =	of He		20a. Method of Disposition 1 ■ Bunial 2 □ Cremat	ion 3 🗆	Removal from		Ob. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	t t	Date	20c. Lo	ocation - City	or Town,	State	
mit Pages	ant: I	-	4 Donation 5 Oth			C	Judean Me	morial Gard	ens	06/2	0/2008	(Olney, l	laryla	nd	
Dem i	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Set	rice Licen	ow	lun	H	22. Name and Addre ines-Rinald 1800 New Ha	i Fun	eral H			oring. h	Marvla	nd 20°	904
	The state of the s		23a. Part1. Enter the disease shock, or heart failure.	e, or comp	olications that	caused the								Apr	proximate erval Betw	veen
Pi	hysician		immediate Cause (Final disease or condition				y Hyperten	gion						Ons	set and D	eath
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ted	nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	⊀	540 1	0 (01 40 4 00	nooquonoo oi).									
, axec	physician and the burial-transit	Examiner	resulting in death) Last		C. Due to	o (or as a co	nsequence of):									
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Tifical O	ng ph as th	ledi	IE EEAAA E.													
th Cert	tendii or use	an/l	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?		23c. If yes, o			□Ectopic pregnanc	:y				23d. Date of	delivery Day	, ,	'ear
The law requires that the death certificate be executed	certificate has been signed by the attending fector, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 🗷 No 9 ☐ Unknown		4□Pre 9□Unk	gnant at time mown	e of death 5	Other (specify) _					World	Day		Cai
r ted	ed by detacl		Part il. Other significant co	nditions o	ontributing to	death but no	ot resulting in the	underlying cause gi	ven in Pa	ırt I.	23e. Did	tobacco	use contribu	te to the ca	ause of de	eath?
COLUS,	signe d be	d by			3			, ,			1 [Yes 2	□ No 3[] Probably	/ 4 X U	Jnknown
	peen	Completed									24a. Wa	s an	24h Wer	e autopsy	findings a	available
<u>ה</u> ק	s has	mp		·							aut per	opsy formed?	prio dea	r to comple th?	etion of ca	iuse of
		e Co	25. Was case referred to me	edical					26 PI:	ace of Dea	1 Yes th (Check only) 1⊔	Yes 2∟] No	
> 1000	s cert	To B	examiner? 1 Yes 2 No		Hospital:	inpatient	2 ☐ ER/Outpatio	ent 3 DOA Ot	hor		ome 5 ☐ Re		6 AOther (Specify)	Hosp	ice
5 6	ter th		27. Manner of Death			e of injury onth, Day Ye	28b. Time	of 28c. Inju			28d. Describe					
STOI1	ath.	atio	2 Accident in	ending vestigatior	1	,,,, = u,, · ·	,		Yes 2	□No						
DIVIS Lor Atte	after de Direct	Certification:		ould not be etermined	28e. Pla	ce of injury - Iding, etc. (S	At home, farm, s Specify)	treet, factory, office			28f. Location City or T	(Street a. own, Stat		or Rural Ro	ute Num	ber,
Hoenita	within 24 hours after death. To the Funeral Director: After this certification is a second of the completely filled in by the funeral director, I	edical C			niner: On the		amination and/or	ath occurred at the tinvestigation, in my)
odt o	within To the Somple	Me	29b. Signature and title of co	ertifier	/	21		29c. Licen	se numb	er		29d. Da	ate signed (M	Nonth, Day	, Year)	
	70		1 Janens	d /	11/1/11	Cer s	& m	п	00646	515		J	une 19,	2008		
9			30. Name and address of pe						all Di		_ 14	1 6	nger			
19620		10		Year) _	32.	Redistrar's	Signature	er Mill Roa	ia, Ko	ockv111	e, Maryl	and 2	לכטט			
	Sta Registi		31. Date filed (Month, Day,	2'0	2008	Calles.	Signature	Contes								

State of Maryland / Department of Health and Mental Hygien UU8

1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Year Mary Katherine Dawson 10:20 a.M June 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Moran Manor Nursing Home Westernport Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 ☐ M 2 😿 F Yrs. Director 87 234-56-5205 Nov. 20,1920 Unknown Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad other than "netural", or items 23a or 28e-f show other treumatic event, the Mcdical Examiner must be notified at 1 Yes 2 □ No Director WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Richmond Street 26726 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ▼ No Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be for and Mental H Charles Brown ဥ (Unknown) Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is in eny injury or other treum once. Henry P. Dawson/Son Rt. 1, Box 177-A Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State June 17 * 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens 2008 Keyser, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Artery Disease disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 should be Progressive dementia; Meningioma; 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М hours after death. Accident within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21266 6/30/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, M.D. 4 Broadway 21532 Frostburg, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For Registrar	State of Mai		artment of F			iene 2008	21765	
			Decedent's Name (First, Middle, Las	st)		inioato or		2. Date of Deat	-	3. Time of Death	
	Physici		Frederick Alber	rt Durlir	na			June 18	, 2008 Year	11:55 A M	
	/Medio Examin		4a. Facility Name (If not institution, give		<u> </u>	4b. City, Town, o	r Location of Death	ounc 10	4c. County of Death		
	CAUTIII		Genesis of LaPla	ta		LaP	lata		Charle	es	
	Funeral		5. Social Security Number 6. Se	ex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	year) 9. Birthplace (State or Foreign Country)		
в	Director		577-44-9740	XM 2□F S	98 Yrs.	Months Days	Hours Mill.	July 24	, 1909 Pana	ama	
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	partico				10d. Inside City Limits	
	shov	5								1 ☐ Yes 2 ☑ No	
	the M	Director	Maryland Char	162	brya	ns Road			Og. Citizen of What Cou		
	with s or	급				' '	1.0	1		muy:	
	eath	era	6719 Amherst Road	12. Was Decedent Ev	ver in U.S. 13 1	206		ecify Yes or No-	U.S.A.	ican Indian	
.	riter d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕱 No			lispanic Origin? (Spi an, Mexican, Puerto		Black, White		
99	urs a	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 X Yes 2 □ No	Specify: Pana	manian	Specify: W	nite	
Ō	filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or Items 23s or 28s-f show ont, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of Business/l	ndustry	
2	thin thin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)				
2	ed will you and you and the truth	S		5+	Forei	gn Servi	ce Office		U.S. State	Department	
pu	be fil tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name				
yla	should and Men s marke umatic	P	Walter Durling					Aroseme			
Mai	C1 (0 = 0	N N	19a. Informant's Name/Relationship (7 Nora Durling-Ott/	,, ,		-			, City or Town, State, Z Maryland		
<u>.</u>	1 end Health em 27	П	20a. Method of Disposition	baugnter	20b. Place of Dispo	sition (Name of	1 -1		20c. Location - City or 1		
<u>5</u>	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			natory or other plac rematory	' 1	5/2008	Waldorf,		
Baltimore, Maryland 21215-0036			21. Signature of Fineral Service Licen			2. Name and Addre			ld Washing		
ä	permit. Departr Importe any inju		Haguell.	Means	1 11/14/11		eral Home		f, Maryland		
			23a. Part1. Egyer the disease, or comp shock, of heart failure. List only	plications that caused the					est,	Approximate Interval Between	
П	Physician		Immediate Cause (Final disease or condition	Cong	KTINK	- 1-45c				Onset and Death	
1	/Medical		resulting in death)	Due to (or as a	consequence of):	1.		C. K.V.		4	
Н	Examiner	_	Sequentially list conditions,	P. 17171	Jusnic	W1014	1. Acros	Cirr	226	mune.	
	si si	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					9	
_	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequence of);					····	
8760,	icate be executed physicien and s the burial-transit	aiE									
687	licate phys s the	edicai		d							
Box (certii nding use a	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deli	verv	
	death e atte d for	iciai	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		Ectopic pregnancy Other (specify)	/		Month	Day Year	
O	t the by the	hys	9 Unknown	9□ Unknown							
S,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?	
ğ	en sig	ed						1 □ Y€	es 2 d No 3 □ Pro	bably 4 □Unknown	
ပ္ပ	law re as be 2 sho	Completed						24a. Was a autops	n 24b. Were au	topsy findings available ompletion of cause of	
<u>~</u>	The ete h page	Con						perform	πed2 death?	2□ No	
ita	Physician: r this certifice ral director, p	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	е)		
5	hysi this c	ဥ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient			A Nursing Ho		ence 6 Other (Spec	ufy)	
Ĕ	After Uner	on:	27. Manner of Death 1 △Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wo		28d. Describe ho	ow injury occurred		
S	death.	icat	2 Accident investigation 3 Suicide 6 Could not be		y - At home, farm, str		Yes 2 □No	29f Location /Cf	reet and Number or Ru	ral Paula Number	
Division of Vital Records, P.O.	for A efter Direct	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	eet, factory, office		City or Town		Tal House Humber,	
_	Hospital 24 hours e Funeral I		29a. Certifying Ph	ysician: To the best of	my knowledge, death	h occurred at the til	me, date and place,	and due to the ca	ause(s) and manner as	stated.	
	To the Hospital or Attending Physician: The law requir within 24 hours effer death. To the Funeral Director: After this certificete has been si completely filled in by the funeral director, page 2 should	Medicai	one)	and manner state	ed.				ate and place, and due		
	To To The	~	29b. Signature and title of certifier	15/1	· m	29c. Licens	number	1	9d. Date signed (Mont)	OB,	
	~	/	Jan H	~~~ 11	V V	7 7 2	.00	('		1 -	
N	IR 7		30 Made and address of person who	Completed cause of dea	atin (item 23a) (Type,	N. V	as she	orr,	Mg SI	26 05	
	Sta Registr		31. Date filed (Month Day Year) 2	2008 32. Registrar	's Signature	arte					
	- Sin.			W. F.							

			1 - State Registrar	Ce	rtificate of	Death		Reg. No. 20	08 2176	
	Physici /Medio		1. Decedent's Name (First, Middle, Last)				2. Date of De Month 06		3. Time of Death	
	Examin		4a. Facility Name (If not institution, give street and number)			or Location of Death		4c. County of		
e e *	-		Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)		polis	8. Date of Bir	Anne A	. Birthplace (State or Foreign	
	Funeral Director		577-22-5951 Usual Residence of Decedent	86 Yrs.	Months Days	Hours Min.	12/12	71921 W	ashington, DC	
	Maryland I-f show	tor	MD 10b. County Anne Arundel	10c. City, Town or Lo Davids	ocation sonville			10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	a or 28s	al Director	10e. Street and Number 3506 Victoria Lane		10f. Zip Code 210	035		10g. Citizen of What Country?		
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Evarines he notified a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 25 Will If Yes, Give	0	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		American Indian, White, etc. White	
2-0036	2 hour	ted l	15. Decedent's Education	16a. Dece	edent's Usual Occup	pation		16b. Kind of Busin	ness/Industry	
212	within 7, jiene. r than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	life.	DO NOT use retire	*	ng		_	
7	filed wi Hygien other th	Co	12	Insur	ance Cle		(First & Aidella	Hospita	11	
yland	be d c	To Be	17. Father's Name (First, Middle, Last) Emmet J. Dowling			Helen C	Clark			
е, маг	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic	8	19a. Informant's Name/Relationship (Type. Print) Thomas Evans Son	1771	7 Elgin 1		sville,	MD 20837		
Baitimore			20a. Method of Disposition 1239 Burial 2. □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	1	Heaven Ce	m 6/23,	/2008		Spring, MD	
מש	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee			ess of Facility Hat y Ave. Ant				
	Physician		23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line Immediate Cause (Final	he do th. Do not en	nter the mode of dying				Approximate Interval Between Onset and Death	
	/Medical Examiner		disease or condition resulting in death) Due to (or as a	consequence of):	cal a	whi	ailu Sterre	m	ulen	
	od ansit	Examiner	Securated by the conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	45 CV				yen	
68/60,	certificate be executed ding physician and se as the burial-transit			consequence of):						
O. 50x 58		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Fetal death 3	□ Ectopic pregnand □ Other <i>(specify)</i> _	су		23d. Date Montl		
as, r	The law requires that the death ate has been signed by the atter page 2 should be detached for u	þ	Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cause giv	ven in Part I.			ute to the cause of death?	
Records,	ne law req s has beel ge 2 shou	Completed					24a. Was	psy pri	ere autopsy findings available or to completion of cause of ath?	
V 11.2	an: Tł tificate or, pa		25. Was case referred to medical			26. Place of Deatl	1 ☐ Yes	2-□No 1 □]Yes 2□No	
>	nysici iis cer direct	To Be	examiner?	at 2 ☐ ER/Outpatie	nt 3 DOA Oth	ner:		idence 6 ☐ Other	(Specify)	
Sion of	ath. r: After the funeral	ation: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day, 2 Accident investigation	Year) 28b. Time o	Wor	ry at rk? IYes 2 □No	28d. Describe	how injury occurred		
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; p	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,	
	he Hospi in 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of and manner state	examination and/or ir	th occurred at the ti nvestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	e cause(s) and man , date and place, an	ner as stated. d due to the cause(s)	
\	With Com	M	29b. Signature and title of certifier AM A	A les	han 29c. Licens		38	29d. Date signed (
	300		30. Name and address of person who completed cause of deal (CHAR)	M M	445 DE	YENSE H	GHWA	TY ANNAP	16,2008 Purs MOZIFU	
	Sta Registra		31. Date filed (Month, Pay, Year) 32. Philistrar 32. Philistrar	's Signature	feele			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

	= = =		_ For	ertificate of Death Reg. No. 2008 21767
П	Physicia	an	1. Decedent's Name (First, Middle, Last) Virgin Emma Fisher	2. Date of Death 3. Time of Death Month Year 7:15am ^M
14 X.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
A.			Marley Neck Care Center	Glen Burnie Anne Arundel Burnie Anne Arundel Burnie Anne Arundel Glen Burnie Anne Arundel Glen Burnie Anne Arundel Glen Burnie Anne Arundel Glen Burnie Anne Arundel
	Funeral Director		5. Social Security Number 436–32–5494 Usual Residence of Decedent	Months Days Hours Min. (Month, Day, Year) Country)
	aryland show dat	_	10a. State 10b. County 10c. City, Town of	Location 10d. Inside City Limits 1 ☑Yes 2 ☐ No
	the Ma 28a-f	Director	MD Anne Arundel Bal	timore 10f. Zip Code 10g. Citizen of What Country?
	3a or		1437 Stoney Point Way	21226 USA
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Marticel Examinar must be mailfied at	by Funeral		3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify: Specify: White
Maryland 21215-0036	n 72 hour "natural	Completed b	15. Decedent's Education 16a. D (Specify only highest grade completed)	ecedent's Usual Occupation 16b. Kind of Business/Industry ive kind of work done during most of working e. DO NOT use retired)
212	y withi	omo	Elementary/Secondary (0-12) College (1-4or 5+)	tress New Canton
pu	0 = 0 %	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ıryla	s 1 and 2 should be 1 Health and Mental Item 27 is marked o other traumatic eve	ဥ	John Edmond Beroular 19a. Informant's Name/Relationship (Type. Print) 19b. N	Irma L. Williams alling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 27 # B			18 Whiterock Ct. Laurel, MD 20723
Baltimore,	31 O		11 IBurial 2 IoUCremation 3 IBemoval from State	sposition (Name of Date 20c. Location - City or Town, State rematory 6/19/2008 Baltimore, MD
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	
đ	Physician		Immediate Cause (Final disease or condition resulting in death)	ARTERY DISEASE STEARS
, apr	/Medical Examiner		Due to (or as a consequence r1)	TIAL HYPERTENSION GYEARS
	± Q	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	THE THE PARTY OF T
	execute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of)	
68760,	tificate be executed by physician and as the burial-transit	edical E	d	
			IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
.O. Box	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year
Vital Records, P.	quires that an signed build be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the CEREBROVALCULAR	e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown
eco	e law requir has been s je 2 should	Completed		24a. Was an autopsy findings available prior to completion of cause of
alF			OF Warrang of world a self-col	performed? death? 1 \ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		To Be	25. Was case referred t edical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	26. Place of eath (Check only one) titient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)
n of	ng Phys After this Ineral di	on: T	27. Mann of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Inju	e of 28c. Injury at 28d. Describe how injury occurred Work?
Division of	Attending r death. ector: After by the funer	ficati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	M 1 ☐ Yes 2 ☐ No street, factory, office 28f. Location (Street and Number or Rural Route Number,
Οį	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
	Hospital or 24 hours afte Funeral Dir stely filled in	Medical	29a. Certifier (Check only one) Check only one) (Check only one) Certifying Physician: To the best of my knowledge, of the basis of examination and/one) And manner stated.	eath occurred at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	١. ٠.	5	> Italy to you	DITION TIME 18, 5000
	XOD	<u>بر</u>	30. Name and address of person who completed cause of death (Item 23a) (Ty Harjit Singh, M.D. 5410A Ritchie Hw	
	Sta	te	31. Date filed (Month, Day, Year) 32 Jegistrar's Signature	Anadi e

DHMH 17 Rev 1/2001

Registrar
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ame and address of pe

Date filed (Month, Day, Year)

JUL 0

2008

ORIGINAL

completed cause of death (Item 23a) (Type, Print)

DIC

08-04941 Frank Lewis Ger	ardi	Please Type of	r Print in Black In of Maryland / Dep	ndelible	Ink. En	sure A	All Copies	s Are Legi	ible.		
		I- For State Registrar			of Death	and i			. No.	200)8 2176
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last) FRANK LEWIS	GERARI	DI JE	ζ.				Day Ye	ear	1751 hrs
4,		4a. Facility Name (if not institution, give 1828B Wheyfield Drive			4b. City, To		ation of Death		4c. County Frederi		
Funeral		Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under	1 Year I	f Under 24Hrs.		(MM/DD/YY)	(Y) 9. Bir	thplace (State or Foreign untry)
Director		<u> </u>	M 2 F		Yrs. Months	Days	Hours Min.	01-10	-1967		
any	,	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation						10d. Inside City Limits
yland -f show	tor	MD FREDE	RICK FK	EDE	RICK 10f. Zip C	code		1100	g. Citizen of V	Vhat Cou	1 Yes 2 No
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director		ELD DRIVE	=	2	170)		US	'A	
th with	Funeral	11. Marital Status Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceden			ecify Yes or No- Rican, etc.)		ce - Amer nite, etc.	ican Indian, Black,
fter dear		3 Widowed 4 Divorced	1 Yes 2 No	1	Yes 2	No s	pecify:		Specify	.WI	HITE
hours afte "natural", Examiner	ted by	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	y highest grade completed) College (1-4 or 5+)		dent's Usual O g most of work				16b. Kind of I	Business	/Industry
5-0036 led within 72 Hygiene. other than '	Completed	Elementary/Secondary (0-12)	College (14 of 54)	5	ALES	5			MEI)IC	AL
	Be Co	17. Father's Name (First, Middle, Last) FRANK LEWIS	SEMARNI S	70		18.	Mother's Name	(First, Middle, M	aiden Surnan		
7. 56 2.9	To B	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma				Rural Route Num	ber, City or To	own, Stat	
alth alth		FRANK L. GERARDI, 20a. Method of Disposition		. Place of Dis	position (Name			EAFOR.	20c. Locatio	n - City o	r Town, State
		1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State		r other place) EST CE	METE	Ry 07	101/08	FEDE	RAL	SBURG, MO
Baltimore, pemit. Pages I a Department of He Important: If ite		21. Signature of Funeral Service Licens	see	12	2. Name and	ddress of	Facility	AL HON	TE OOG	2 211	. 27
Physician		23a. Part I. Enter the disease, or compl		th. Do not en	3/1 S. // ter the mode of	dying, su	ch as cardiac o		RGMC est, shock, or		Approximate Interval Between Onset and
/M. dical (caminer			Complications		ronic	alcoh	olism				Death
,		Sequentially list conditions, b.	Oue to (or as a consequence	3 017.							
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence				_				34
and and transit		events resulting in death) Last d.	Due to (or as a consequence								
	dical	X UNPENDED X	AMENDED#1 as n	perMi oted p	er ME (8/11 882	/08 TT 8/11/08	3 T T			
Box 68760, te death certificate be ex the attending physician red for use as the burial	an/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	2	Fetal death	3	Ectopic pregna	ancy	23d. Date Month		Day Year
30x 6 death ce e attend I for use	sici	1 Yes 2 No 9 Unknown	Pregnant at time of Unknown	death 5	Other (Spec	ify)					
P.O. Box 68760, so that the death certificate be gened by the attending physic one detached for use as the burner burners.	by Phy	Part II. Other significant conditions	contributing to death but no	ot resulting in t	the underlying	cause give	en in Part I.	23e. Did to			to the cause of death?
ords, P.O. v requires that the sheen signed by should be detach								24a. Was autop	an 24		autopsy findings available o completion of cause of
Recor The law I cate has I	Completed								med?	death?	
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?	lospital:	ER/Outpa			Death (Check		Residence	6 V Ott	ner: Scene
Division of Vital Records, tal or Attending Physician: The law require and aged each. The retuing the service and been side from the funeral director, page 2 should be in by the funeral director, page 2 should be	n: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time		8c. Injury	Truisii	28d. Describe			ior. Godino
ivision or Attendii after death. Director: A	ertification:	1 X Natural 5 Pending 2 Accident Investigati		A bomo form	etroet fectory		s 2 No	28f Location (Street and Nu	imber or	Rural Route Number, City
Division Pital or At ours after derail Direct filled in by	ertifi	3 Suicide 6 Could not determine	be	it florite, farm,	Street, ractory,	Onice buil	arrig, etc.	or Town, S			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be exwithin 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	ical C	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of my knowl	ledge, death on and/or inves	occurred at the	time, date	and place, and leath occurred	d due to the caus at the time, date	se(s) and mar and place, ar	nner as st nd due to	ated. the cause(s)
To 1 with To 1	Medical	29b. Signature and title of certifier	and manner stated.			. License i	number		29d. Date s	signed (A	Month, Day, Year)
		Unes 2				O.C.M	.E.		June 27	, 2008	
		30. Name and address of person who Ana Rubio MD. Assista	completed cause of death (II nt Medical Examiner		nn Street, E	altimore	e, MD 2120)1			
S Regis	tate	13.14 11 / 211110	32. Registrar's star	nature	les .						
Regis	الثانه	7.7	£								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 17,2008 **Physician** 9:00am м Rosana Maria Gatti /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6413 Greentree Rd Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 16,1960 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Paraguay Director 578-82-6165 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show alcal Examiner must be notified at Md Bethesda 1 Yes 2 No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with United States 6413 Greentree Rd 20817 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1⊠Yes 2□No Specify: South American Specify: White Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Megonee. College (1-4or 5+) Elementary/Secondary (0-12) ESOL Consular Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gustavo Gatti Livia Nunez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Livia Gatti/ Mother 6413 Greentree Rd, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Crematory 6-19-08 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC Funeral/Service License 21. Signatu Yes 5130 Wisconsin Ave, N.W. Washington DC 20016 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer 6 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate audo. Enter undering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending Injury 1 Natural 5 Pending To the nosperation 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Dr. Fred Smith 5454 Wisconsin Ave, N.W. #1300 Bethesda, MD 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature JUN 2 0 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0033293

29d. Date signed (Month, Day, Year)
June 18,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ye ar **Physician** 2008 Lorraine Alberta Harne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. April 4, 1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F Mary Land 219-34-5147 72 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. It. Micel Examination once. 1 ☐ Yes 2 No Director Md. Frederick Smithsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13123 Martin Rd. 21783 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ∐Yes 2 XIIII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White ò 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John M. Bear Sr. Hattie M. Eccard ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce J. Feuerstein (Daughter) 13123 Martin Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of Saleme University Methodist June 30, 20c. Location - City or Town, State 20a. Method of Disposition ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State Wolfsville, Md. 2008 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Jeffrey Lee L MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Tue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or carlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Fibrillation 24a. Was an has page 2 s autopsy certificate 1 □Yes 2 No the Hospital or Attending Physician; this certific al director, 25. Was case referred to medical examiner? 26 Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

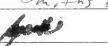
State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

29d. Date signed (Month, Day, Year)

ms

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05063 State of Maryland / Department of Health and Mental Hygiene 2008 21772 Randolph C. Hodgson Certificate of Death 1- For State 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month D. July 1, 2008 Day 1257 hrs Randolph Christian Hodgson Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 1645 North Calhoun Street Apt. 302 If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours MD Months Davs Country) July 12,1965 Director 42 Yrs 212-84-7578 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore City MD "natural", or items 23a or 28a-f show Examiner must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 ISA 1645 North Calhoun St. Apt.302 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married Yes Specify: White Yes 2X No specify: If Yes, Give Yea 4 Divorced 3 Widowed \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Restaurant Waiter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Lee Forbes William Hodgson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Parkville, MD Betty L. Hodgson/ Mother 8505 Wendell Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State Evans Funeral Forest Hill, MD Chapel-Bel Air Donation 5 Other Specify: 22. Name and Address of Facility Evans Funeral 8800 Harford 21. Signature of Funeral Service Licensee Chapel & Cremation Rd. Parkville, MD 21 Approximate Interva 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and ysician failure. List only one cause on each line Death Medical a Fentanyl intoxication Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last AMENDED 23a, PII,27,28a-f, perME, G881 7/18/08 TT and Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial 23d. Date of delivery O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day 3h. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown ģ Cocaine use Completed 24b. Were autopsy findings available Division of Vital Records, 24a. Was an page 2 should prior to completion of cause of death? performed? has 1 🗸 Yes 2 No ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Nursing Home 5 Residence 6 ✔ Other: Scene Other Hospital: examiner? ER/Outpatient 3 Inpatient 2 this 1 🗸 Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 1 Yes 2 X No Natural Fnd 12:40pm Fnd 7/1/08 Pending hours after death. filled in by the 2 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1645 N. Calhoun St Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be or Town, State) 1645 N. Apt 302 Baltimore, Suicide (Specify) found at residence within 24 hours a To the Funeral 1 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) g 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier July 2, 2008

State Registra

Registrar's Smature

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Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Tasha Greenberg MD.

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Richard Janigian Jr. June /Medical 4a. Facility Name (If not institution, give street and 4c. County of Death City, Te wn, or Location of Death Examiner Balt Baltimore Hospi 7more 4a (If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** 579-34-3814 1 XM 2 ☐ F Davs Hours Washington, DC Director 12/16/1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Frown as Janigian, Richard Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evaninar must be neutified any energy. 1 X Yes 2 □ No Director Washington DC 10g. Citizen of What Country? 10e Street and Number 10f Zin Code United States 20016 4211 Alton Place NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 Kayes 2 □ No If Yes, Give War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 K∆Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kanarig Kalpachian Dickran Janigian ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Janigian / Brother 4211 Alton Pl. NW Washington, DC 20016 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/23/2008 Rockville, MD Parklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tue to for as a consequence of Examine requires that the death certificate be executed Due to (or as a consequence of). burial-P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: use a f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No the 9 Unknown 9 🗀 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown page 2 should Completed disease 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an has autopsy performed? certificate 2 **N**O 1 🗆 Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

within 2 To the I

3

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and manner stated

32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

June 16, 2008

08-05088 Amirah Leigh Kline

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21774

		For State		Certificate of Death					Reg. No.			
Physicia edical Examin	n/ 1	Decedent's Name (First, Mid Amirah		eigh	Kline				Month Day Year July 2, 2008			3. Time of Death 0901 hrs
	4	la. Facility Name (if not institut Western Maryland H	ion, give street and nu ealth System, Me	^{mber)} emorial Campu		c. City, Town, Cumberla		of Death		Alle	ounty of Dea gany	
Funeral Director	5	5. Social Security Number 218-81-8438	6. Sex	7. Age (In yrs. last	birthday) Yrs.		ear If Und ays Hour 28	er 24Hrs. Min.		/2008	Fore	sirthplace (State or eign Maryland Country)
any		Usual Residence of Decedent		10c. City, To	wn or Location				1007.05	7200		10d. Inside City Limits
<u>*</u>	5_		llegany		Cumberland					10g. Citizen	of What Co	1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 975 Willi	lliams Street			Tor. Zip Cou	21502	2	5		U	ISA
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral		Married Armed F	2 X No	If Ye	Decedent of es, specify Cu	ban, Mexica	in, Puerto	ecify Yes or I Rican, etc.)		White, etc.	
urs after itural", o	<u>a</u>	3 Widowed 4 5. Decedent's Education (Sp	Divorced If Yes, Give Yes or Dates: pecify only highest gra		6a. Decedent	Yes 2 X t's Usual Occu	pation (Giv	e kind of w			d of Busines	Black ss/Industry
336 thin 72 ho ne. than "na ledical Ex	Completed	Elementary/Secondary (0-1:	2) College (1-4 or 5+)	0	Infant					None	
MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than unmaric event, the Medica	Be Con	17. Father's Name (First, Midd Unknown	lle, Last)				As	shley		e, Maiden Su Regi	ina	Kline
D 212 should b and Meni 7 is marl	101	19a. Informant's Name/Relation		r		Address (S Willian						ate, Zip Code) 21502
ore, M ses I and 2 of Health If item 2 ther traur	1	20a. Method of Disposition 1 X Burial 2 Cremat	Place of Disposition (Name of cemetery, rematory or other place) Date 20c. Location - City or Town, State 20c. Location - City or Town, S									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	1	4 Donation 5 Other 21. Signature of Funeral Servi		<u> </u>	22. 1		ress of Fac	ility Ada	ams Fai	mily F	unera	1 Home, P.A.
Physician	-	23a. Fall Enter the disease, failure. List only one cau	or complications that	caused the death. D								Approximate Interval Between Onset and
Medical aminer		Immediate Cause (Final diseasor condition resulting in death	ase a Sudder	a consequence of):		eath i	n inf	ancy		72		Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau		a consequence of):								
nted d ansit	Examiner	(Disease or injury that initiate events resulting in death) La	d Due to (or as	a consequence of):								
760, cate be executed physician and the burial - transit	edical	X UNPENDED		, 23a, 27, 2		perME,	g883	9/4/	'08 TT	23d.	Date of deli	ivery
	₹	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	n the 1 Live	, outcome of pregna birth gnant at time of dea	2 F6	etal death ther (Specify		opic pregn	ancy		Month	Day Year
that the death or red by the atten detached for us	Physician	1 Yes 2 ✓ No 9 Part II. Other significant con		to death but not res	sulting in the	underlying ca	use given ir	Part I.				e to the cause of death?
S, P.O. quires that the signed by all de detach	ted by	-							24a. V	Vas an	I 24b. Wer	Probably 4 V Unknown re autopsy findings available
of Vital Records, P.O. Box 68' ng Physician: The law requires that the death certifi ther this certificate has been signed by the attending meral director, page 2 should be detached for use as	Completed								p	utopsy erformed? es 2 No	deat	r to completion of cause of th? Yes 2 No
	Be C	25. Was case referred to med examiner?	dical Hospital:		5D/0.4=-4ia-		Place of De Other		only one)	Resider	nce 6 C	Other:
1 of Virting Physic. After this funeral dir	To	1 Yes 2 No 27. Manner of Death	28a, Da	Inpatient 2 1 te of Injury nth, Day,Year)	28b. Time of		: Injury at V	Vork?		ribe how inju		
Division tal or Attendi rs after death.	Certification:	2 Accident I	Could not be 28e. Pi	7/2/08 ace of Injury - At ho found	Fnd 8:	eet, factory, o	ffice building		28f. Locati	on (Street ar	00 Be	r Rural Route Number City
sspi hou net		4 Homicide	g Physician: To the b Examiner: On the bas	fy)	e death occ	urred at the til	ne date an	d place, ar	d due to the	cause(s) and	d manner as	s stated.
To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of ce	and manne	r stated.		29c.1	icense num			29d. [Date signed	(Month, Day, Year)
		30. Name and address of pe	rson who completed co	ause of death (Item	23a)	(D.C.M.E.			July	3, 2008	
		Russell Alexander	MD. Assistant	Medical Exam	iner 11	1 Penn St	reet, Balt	imore, I	MD 21201			
S Regis	tate strar		0 7 2008 32.	Registrar's Signatu	Ja /	hack					ME	
DHMH 17 Rev 1/	2001	JUL	1	Jacob Comment of	ORIGIN	AL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12/2008 Year Physician 6:55 pm John A. Kamm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 4 1 2 1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1∰M 2□F 973071927 Hours Washington, DC 80 218-20-2190 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts 1 □Yes 26 No Directo Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5823 Deale Beach Rd. 20751 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 SarYes 2 □ No 1945 — If Yes, Give 1 Never Married 2 Married 1 ☐ Yes XX No White 2 3 XWidowed 4 ☐ Divorced Year or Dates: 1947 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Adam Kamm Ruth Irene Burger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28480 19a. Informant's Name/Relationship (Type. Print) Son 16E Greensboro St. Unit A Wrightsville BCH, NC John Kamm Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lakemont Mem Gardens 6/16/2008 Davidsonville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 12 Ridgely Ave. Annapolis, MD 21401 0 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Exacerbation of Chronic Obstructive Pulmonary Disease **Physician** 38 34 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Monic page 2 s autopsy performed' To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) C0002641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Crowder Pkwy, Annapolis, MD, 21401 2001 Medica 31. Date filed (Month, Day, Year)

JUN 1 9 2008 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jeanne Month une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Columbia if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
May 11, 1933 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 22 N Months Hours Min. Maine 003 22 6124 Director Usual Residence of Decedent the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Prince George Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e Pages 1 and 2 should be filed within 72 hours after death with 4 G Laurel Hill Rd. 20770 rai", or items 23a Examiner must b United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 Widowed 4 □ Divorced "naturai", 1952-55 White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, it once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Moulton Jeanne Merguin ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen S. Romanczyk/Daughter 13064 Deanmar Drive Highland, MD 20777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 6-20-2008 Hanover, MD 21. Signature of Funeral Service Licenses M01044 Harry H. Witzke's Family FH Inc. Olling 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Narian disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trar P.O. Box 68760 physician Physician/Medical the i ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗶 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No ပို Inpatient this 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death lospital or Attending P I hours after death. uneral Director: After t 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural (Month, Day 1 ☐ Yes 2 🗆 No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number Bell Care Clarlised who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar

DHMH 17 Rev 1/2001

State

JUN 2 0 2008

Year)

31. Date filed (Month, Day,

Registrar's Signature

Meters & Sparle

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6/16 2008 Month Physician Eric G. Lindahl 7:10pmM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Ginger Cove . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9/15/1914 9. Birthplace (State or Foreign Country)

IL 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 T F 93 Director 312-09-7030 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, The Ancical Examination to use the natified at 1 □Yes 2 X No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 USA 7307 Rivercresent DR. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 ∐ Yes 212 No ≥ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US State Dept. Foreign Service Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Signe Olsson Gustav Lindahl ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau once. Son 421 Edgemere Dr. Annapolis, MD 21403 Michael Lindahl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 6/19/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 Jan, 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each judg. Approximate Interval Between Onset and Death cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequent Examiner Sequentially list conditions, Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. detached 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performed? ospital or Attending Physician: Theoris after death.
Ineral Director: After this certificate by filled in by the funeral director, pa 1 □Yes 2 □ 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Tes 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation **Da**atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) My Year) egistrar's Signature 31. Date filed (Month 9 2008

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2008

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Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6/16/2008 **Physician** 5:00pm Gertrud Lindahl /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Ginger Cove Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 25 XF 545-58-3872 2/8/1918 Sweden Director 90 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Wodlest Examiner must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7307 Rivercrescent Dr. 21401 IISA death v by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 3 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event Be Eric August Carlberg Alma Linell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric G. Lindahl 7307 Rivercrescent Dr. Annapolis, MD 21401 Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 6/19/2008 Baltimore. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as consequence of): The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months Day Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ♣ To 24a. Was an has autopsy certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 🗚 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 28b. Time of Injury 27 Manner of Deatl 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) einel Due Stelled t 30. Name and address of person who co pleted cause of death (Item 23a) JUN 1 9 2008 32. Registrar's Signature Registrar

		1- State of Maryland / Department / Department / Departmen	rtment of Health and Mental Hygiene 2008 21780
Physicia /Medica			nbest 2. Date of Death Month Day Year June 16 2008 16 52 PM
Examine	er	4a. Facility Name (II not institution, give street and number) The Johns Hopkins Hospital	4c. County of Death Baltimore City If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9, Birthplace (State or Foreign
Funeral Director		5. Social Security Number 218-44-8094 1 X M 2 D F 7. Age (In yrs. last birthday) 62 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 27,1945 Maryland
Maryland a-f show fied at	ctor	10a. State 10b. County 10c. City, Town or Loc	ation aro Beach 10d. Inside City Limits 1 № Yes 2 □ No
th with the 23a or 28 st be noti	Funeral Director	10e. Street and Number 977 Hillsboro Mile	10f. Zip-Code 10g. Citizen of What Country? USA
D36	[ج	Armed Forces? 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Specity Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □ Yes 2 ☑ No Specify: Specify: White
21215-0036 ad within 72 hours aft gliene. er than "natural", or the Medical Examir	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 16a. Deceding (Give in the control of t	ent's Usual Occupation Ind of work done during most of working O NOT use retired) Eveloper Real Estate
Maryland 2121 d 2 should be filed within th and Mental Hygiene. 27 is marked other than " traumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last) Robert Sidney Bernstein	18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Bowling
, Mary and 2 sho saith and N 27 is ma er trauma		1.77	g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hillsboro Mile Hillsboro Beach, FL 33062
altimore, mit. Pages 1 a partment of Hee portant: If Item y Injury or othe		4 Donation 5 Other (Specify) Metro Cre	ematory June 17, 2008 Baltimore, Maryland
Balt permit Depart Import any Inj once.		21. Signature of Funeral Service Licensee 22. Box 49 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	Name and Address of Facility Arranco & Sons, P.A. Severna Park Funeral Home Sov. Ritchie Hwy, Severna Park, MD 21146 or the mode of dying, such as cardiac or respiratory arrest. Approximate
	cal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (order a consequence of):	Pneumonia Interval Between Onset and Death
Box 68 death certific death certific e attending ped for use as	Physician/Medical		Ectopic pregnancy Other (specify) 23d. Date of delivery Month Day Year
	2	Part II. Other significant conditions contributing to death but not resulting in the unit conditions Lung disease, Lung Cancer	
The law requate has been page 2 shou	Completed	Stricture	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 【X No 1 □ Yes 2 【X No
of Vital Physician: Tr this certificate eral director, pa	To Be C	25. Was case referred to medical examiner? 1 □ Yes 2 💢 No Hospital: 1 💢 Inpatient 2 □ ER/Outpatient	26. Place of Death (Check only one) 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)
On Alling fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, streen building, etc. (Specify)	Work? M 1 □ Yes 2 □ No
Hospital 4 hours Funeral tely filled	Medical Cer		occurred at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within 2 To the comple	Mea	29b. Signature and title of certifier Tariu Neurel deen	29c. License number 29d. Date signed (Month, Day, Year) 6/16/2008
200	٢	30. Name and address of person who completed cause of death (Item 23a) (Type,	
Stat Registra	e	31. Date filed (Month, Pay, Year) 2008 Registrar's Signature	

		1	For State Registrar	tate of Maryla	•	rtment of Hea tificate of De		ental Hygie	ene 3. No. 2008			
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Death	OOS Year	3. Time of Death 8:45 Рм		
	/Medic	al	Roy Merwin J			4b. City, Town, or Loc	cation of Death	- 20 1	4c. County of Death			
	Examin	er	College View Cente			Frederick			Frederick			
	uneral rector	- 1	5. Social Security Number 6. Sex 15 N	2□ F 7. Age (In yn	s. <i>last birthday)</i> Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2–10–19)	Year) 9. Birth Con	nplace (State or Foreign Intry) NE		
pue	M.	- H	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City Limits		
BAITIMOFE, IMATYIAND A LAID-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Evanitry ment is conflict at once.			MD Frederick		Frederi	ck				1 □ Yes 2 A No		
		Funeral Director	10e. Street and Number	irro		10f. Zip Code 21702		10	g. Citizen of What Cor USA	untry?		
eath w	ns 23a	eral	2100 B Whittier Dr.	Was Decedent Ever in	U.S. 13. \	Was Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Spe	ecify Yes or No-	14, Race - Ame			
OUSO hours after de ural", or item		by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ◯ Divorced	Armed Forces? 1 ⊉Yes 2 □ No If Yes, Give Year or Dates: WW			Mexican, Puerto Specify:	Hican, etc.)	Specify: Wh			
2-C	natura Jicel E	eted	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16a. Deced	dent's Usual Occupation kind of work done duri DO NOT use retired)	on ing most of worki	ing 1	6b. Kind of Business/	Industry		
within and	than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	oo <i>not use retired)</i> puter Elec			Sole Prop	rietor		
filed A	other ent, II	Be	17. Father's Name (First, Middle, Last)			1		(First, Middle, M	laiden Surname)			
Viand vuld be file	arked atic ev	70 B	Roy Merwin Sr Chikhown						At the second of			
Mar d 2 sho th and	7 is m traum		19a. Informant's Name/Relationship (Type. Print) Brock Merwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 648 Wilson Place Frederick, MD 21702							up code)		
is tan	item 2		20a. Method of Disposition	20b	. Place of Dispo cemetery, crer	sition (Name of natory or other place)	1	Date 2	20c. Location - City or	Town, State		
Saltimore, permit, Pages 1 ar	ant: If		1 ☐ Burial 2 X Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	mithsbu	rg Crem.	7-1-		Smithsburg			
Denait Denait	Impor any in		21. Signature of Funeral Service Deensee	hand MOI	.176	2. Name and Address of Ch	urch St	ney & Ba . Freder	ick, MD 21	701		
	sician ledical		23a. Part 1 Inter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the decause on each line. END STAC Due to (or as a cons	& R	ter the mode of dying,			est,	Approximate Interval Between Onset and Death		
S 60, cate be executed	physician and stree burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons								
I Records, P.O. Box 6 The law requires that the death certifi	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	b. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year		
dS, P.	been signed by the should be detached		Part II. Other significant conditions conti	ibuting to death but not					oacco use contribute t es 2 □ No 3 □ P	o the cause of death? Probably 4 Unknown		
Division of Vital Records, for Attending Physician: The law requires t	has le 2	Completed by	HYPER MENSION					24a. Was a autops perfori	med? prior to death?	utopsy findings available completion of cause of		
/ital	certificate rector, pag	BeC	25. Was case referred to medical examiner?	eniteli		Other		th (Check only on				
Vision of Vita	n. After this o funeral dire		1 Yes 2 No	spital: 1 ☐ Inpatient 2 28a. Date of Injury	28b. Time o	nt 3 🗆 DOA	4 E Nursing H		ence 6 Other (Sp. ow injury occurred	ecify)		
ion	geam. ctor: Afte y the fune	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year	r) Injury		es 2□No					
ivis or Atte	aner deam Director: /	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	at home, farm, st ecify)	reet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,		
Hospital	within 24 hours after of To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin one)	cian: To the best of my er: On the basis of exan and manner stated.	knowledge, dea nination and/or i	th occurred at the time nvestigation, in my opi	e, date and place nion, death occu	e, and due to the d irred at the time, d	cause(s) and manner a	as stated. se to the cause(s)		
the	ormple	Med	29b. Signature and title of certifier			29c. License	number	i	29d. Date signed (Mor			
	> - 0		Dowlor	MD		0219	136		6/30/0	8		
	Ø		30. Name and address of person who cor				rođána al-	. MD 21	701			
	-	ate	Dr. Andrew O. Done	elson M.D.	ignature	J. Drive Fi	euerick	, FID ZL	OL			
	Regist		1111 0 7 2008	Marie L	The Land	13.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 19, 2008 1:15 P M Florence Fehlmann Myers 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Silver Spring Bedford Court If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Dav. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex Days New York 1919 1□M 2 F June 89 488-22-4221 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 TYes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20906 3700 International Drive Suite 242 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Healthcare Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unk) Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1717 Priscilla Drive Silver Spring, MD 20904 Phyllis Newman/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 06/20/08 Beltsville, MD Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause or each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ne past 12 months? Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? her significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2|JK6 1 Yes 26. Place of Death Check onl one Was case referred to medical examiner? Other: 1 ☐ Yes 2000 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Dother (Specify, 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 1 Maturai (Month, Day Year Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the bunal-tran Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 271s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ounce.

Baltimore, Maryland 21215-0036

Examine Be Completed by Physician/Medical

in th 1 🗆 9 🗆
Part II. Ot
25. Was

29a. Certifier

(Check only one)

29b. Signature and title

Medical Certification: To

filled in by the funeral director, page 2 should

After 1

death.

24 hours after death e Funeral Director:

the the

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191	0	

State Registrar 27. Mann of Death

6 ☐ Could not be determined 4 | Homicide

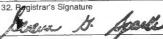
> 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name end address

JUN 2 0 2008



		•	1- State of Maryland / Depa Registrar Cert	rtment of Health tificate of Deatl	and Mental F h	lygien Reg. N		21783
H	Physici /Medic		1. Decedent's Name (First, Middle, Last) Lois Michael Morris		2. Date of June		^{ay} 2008 ^{ear}	3. Time of Death 6:24A. M
}	Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location Takoma Pa		4	c. County of Death Montgome:	ry
	Funeral Director		5. Social Security Number 235-34-0390 6. Sex 1	If Under 1 Year If Under Months Days Hours	or 24 Hrs. 8. Date of Min. March	Birth 21, T	9. Birthp	lace (State or Foreign
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's Beltsville				1	0d. Inside City Limits 1 ☐ Yes 2 No
	h with the 23e or 28a at be notif	al Direc	10e. Street and Number 11710 Emack Road	10f. Zip Code 20705			Citizen of What Cour United St	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Depertment of Heelth and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow important: If Item 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow erry injury or other traumatic event. I'm Medical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	Yes Decedent of Hispanic C Yes, specify Cuban, Mexic Yes 2X No Specif		No-	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	nin 72 ho n "natur Vertical	Be Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during mo O NOT use retired)	ost of working	16b.	Kind of Business/Inc	dustry
21	ygiene ygiene her the	Com	Elementary/Secondary (0-12) College (1-4or 5+) Lay-Ch				ted Campus N	/inistries
/land	uld be fi Mental H irked ot itic ever	To Be	John G. Michael		her's Name (First, Mid Irey Delle			
, Mary	and 2 sho selth and h 27 ie ma er trauma			Address (Street and Num Emack Road E		-		Code) 705
Baltimore,	Pages 1. ment of He ant: If Item		20a. Method of Disposition 1 Burial 2 Peremation 3 Removal from State 4 Donation 5 Other (Specify)	ition (Name of atory or other place) can Crematory	Date 7 6/19/2008	20c.	Location - City or To exandria,	
Balt	Departi Depart Import eny in		21. Signature of Funeral Service Licensee	Name and Address of Fac 181d V. Borgw 10 Powder Mil	värdt Funer l1 Road Bel	al Ho	ome, PA 11e. Marv	land 20705
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a					Approximate Interval Between Onset and Death
	Examiner	-	Due to (or as a consequence of)	ryopath	4			
oʻ.	ficate be executed physicien and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
68760,		edicai	d					
O. Box	The law requires that the death certifi tie has been signed by the attending page 2 should be detached for use as	Physician/M		Ectopic pregnancy Other (specify)		-	23d. Date of delive Month	ery Day Year
٥.	w requires that the base by should be detact	٥	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Pari		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknow		
Division of Vital Records,		Completed			pe	as an itopsy prormed? s 2 2 N	prior to con death?	psy findings available mpletion of cause of
V Its	s certifi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	Othor	ce of Death (Check on Nursing Home 5 R		6 DOther (Second	ul
o uo	ding Physician: The Ih. h. Atter this certificate ha funeral director, page		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2	28d. Descri		ury occurred	
Divisi	To the Hospital or Attending Physician: within 24 hours elfer death. To the Funeral Director Attenthis certification to the Funeral director, completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)		28f. Locatio	n (Street a Town, Sta	and Number or Rura te)	I Route Number,
	To the Hospital or A within 24 hours effer To the Funeral Director Completely filled in by	edicai C	29a. Certifier (Check one) (Ch	occurred at the time, date a estigation, in my opinion, de	and place, and due to to the tine	he cause(ne, date a	s) and manner as sind place, and due to	tated. the cause(s)
)	To the compl	Me	29b. Signature and title of certifier	29c. License numbe	47	29d. D	Pate signed (Month)	Day, Year)
	0,0		30. Name and address of person who completed cause of death (Item 23a) (Type, P	Ave Takn	ma Park.	Mol	Dogin	υθ
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Refistrar's Signature 32. Refistrar's Signature	reales				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

		ľ	For State Registrar			rtificate of L			Reg. N	2000	21/84	
ı	Physici		Decedent's Name (First, Middle, Lass SAM	A.	MORG	ENSTEIN		2. Date of Dea Month JUNE 17	D	Year 2008	3. Time of Death 9:26 A M	
المالية	/Medic Examin		4a. Facility Name (If not institution, give		HORG		Location of Death	JOHE 17		c. County of Death		
j.			15115 INTERLACHEN	DRIVE #414			ER SPRING		MONTG	OMERY		
	Funeral Director		5. Social Security Number 6. S 161–20–9976 1. Usual Residence of Decedent	ex 7. Age (II	94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 10/02/	y, Yea	r) Cou	place (State or Foreign intry) RUSSIA	
	Maryland a-f show iffied at	ctor	10a. State 10b. County MARYLAND MONTGO		c. City, Town or Lo	SILVER	SPRING				10d. Inside City Limits M☐Yes 2☐No	
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 15115 INTERLACHEN	DRIVE #414		10f. Zip Code	.0906		10g. C	Citizen of What Cou USA	intry?	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Italian Emminer must be notified at once.	d by Funeral	11. Marital Status 1 Never Married	12. Was Decedent Ever Armed Forces? 1	1	Was Decedent of Hi If Yes, specify Cuba 1 □Yes 21 No		ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White, Specify: V		
1215-(vithin 72 h	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of work)	ing		Kind of Business/Ir		
Baltimore, Maryland 21215-0036	ld be filed v lental Hygie ked other t ic event, Ih	To Be Co	17. Father's Name (First, Middle, Last) MAX MORGENSTEIN			ECONOM	18. Mother's Name			U.S. GOVE en Surname)	ERNMENT	
, Mary	and 2 shou saith and N n 27 is mar er traumat		19a. Informant's Name/Relationship (GWEN ZUARES, DAUG	HTER	6940 C	ng Address (Street a PREGEON AV	ENUE, NW	al Route Numbe WASHIN	er, City	ON, DC 2	ip Code) 20015	
timore	tment of H tant; if iten		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OLNEY, IN State JUDEAN MEMORIAL GDNS OF 18/2008 OLNEY, IN State JUDEAN MEMORIAL GDNS OF 18/2008							NEY, MARY		
Ba	permi Depar Impor any in		21. Signature of Funeral Service Licen	see		2. Name and Addres DWARD SAG 091 ROCKV	s of Facility EL FUNERA ILLE PIK	AL DIRECE, ROCKY	CTI VIL	ON, INC. LE, MARYI	LAND 20852	
i de de de	Physician /	67 5	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE DEMENTIA Due to (or as a consequence of): Approximate Interval Between Onset and Death of MONTH:									
	Examiner	e.	Sequentially list conditions,		ATING HYD	ROCEPHALU	S		_		3 YEARS	
<u>,</u>	ficate be executed physician and s the buriat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a co	ensequence of):							
68760	certificate be executed iding physician and ise as the burial-transit	Medical		. d								
.O. Box	The law requires that the death cert ite has been signed by the attending age 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)				23d. Date of deli Month	very Day Year	
rds, P.	w requires that been signed to should be deta	ρ	Part II. Other significant conditions of AORTIC STENOSIS	ontributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.				the cause of death?	
		Completed								prior to c death?	topsy findings available completion of cause of 2 No	
Vita	Ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		1044	26. Place of Deat			_1		
ō	Phys rr this eral dir	.: To	1 Yes 2 ★No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		4 LI Nursing Ho	ome 5 🔀 Resid		6 ☐ Other (Specially occurred	eify)	
o	ath. r: After re funer	atior	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Ye	ear) Injury	of 28c. Injury Work M 1 □	? Yes 2□No					
Divis	pital or Attending Physician: ours after death. eral Director: After this certificalied in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (5	At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Tou	Street vn, Sta	and Number or Ru ate)	ral Route Number,	
	To the Hospital within 24 hours a To the Funeral C completely filled	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or it	th occurred at the tir nvestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause date a	e(s) and manner as and place, and due	stated. to the cause(s)	
	30	Σ	29b. Signature and title of certifier	n Mg		29c. License	D24543			UNE 17, 2	-	
				completed cause of death			VD CTIV	ידממט מק	īC.	MADSITAST	20006	
	Sta	_	DR. JAMES A. ROS	32. Registrar's	Signature	Social BL	νν, ότην	EK SEKII	Y G,	TIAK I LANL	20906	
	Registr	ar	JOH NO	THE STATE OF	and so f							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 16, 2008 June Mildred S. Miller /Medical 4c. County of Death 4h City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gaithersburg Montgomery Wilson Health Care Center If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 X F 85 Mar. 15, 1923 Washington, DC Director 215-50-9281 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 317 Lorraine Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21x No Specify: White Specify by Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Riggins F. Douglass Sears 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 307 Charles Street Rockville, MD. 20850 April C. Goss (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 20. 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, MD. Parklawn Mem. Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home TRACY A 10 East Deer Park Drive Gaithersburg, MD. 20877 JTues Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) re-month **Physician** /Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 W No History 1□ Yes 26. Place of Death (Check only one) Medical Certification: To

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760, ompletely filled in by the funeral

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner?

1 Yes 2 P No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to the castifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

JUN 2 0

164. Report Birschbarfurs DO4115 Lenne 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL ABENUE

14. ROBERT BIRSCHBACH, NND 6AITHERSBURG, NID 208777 32. Ragistrar's Signature Caller

6 (6

		nt in Black Indelible Ink. En aryland / Department of Healt		•				
	1 - State Registrar	Certificate of Dea	th Reg. N					
Physician /Medical	TLGIA NOST		2. Date of Death Month	ay Zyear 16:42, M				
Examiner Funeral	4a. Facility Name (If not institution, give street and number) 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday) If Under 1 Year If Ur	nder 24 Hrs. 8. Date of Birth	c. County of Death 9. Birthplace (State or Foreign Country)				
Director	217-03-8069	88 Yrs. Months Days Hou	2/3/1920	MD 10d. Inside City Limits				
or 28a-f show	MD Anne Arunde1 10e. Street and Number	Odenton	100. (1 □Yes 2X No				
eath with is 23a or must be or	555 Williamsburg Lane 11. Marital Status 1 Never Married 2 Married States 2 1	21113		USA 14. Race - American Indian,				
S as o	☐ 3XXVidowed 4 ☐ Divorced If Yes, Give Year or Dates:	No 1939- If Yes, specify Cuban, Mex	xican, Puerto Rican, etc.)	Black, White, etc. Specify: White				
within 72 h ene. than "natu he Medical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	16a. Decedent's Usual Occupation (Give kind of work done during iffe. DO NOT use retired) Colonel	most of working 16b.	Kind of Business/Industry US Army				
uld be filed Mental Hyg Inked other atic event, I	17. Father's Name (First, Middle, Last) Algia Hearn Nash Sr.	18. N	Mother's Name (First, Middle, Maide Mabel Evick					
and 2 should I am 27 is marke alth and Men n 27 is marke ser traumatic.	19a. Informant's Name/Relationship (Type. Print) Lucy Nash Daughter	19b. Mailing Address (Street and No. 555 Williamsburg						
permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trai	20a. Method of Disposition ★★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Ce		Location - City or Town, State				
permit. Departinit importa any inju	21. Signature of Funeral Service Licensee	22. Name and Address of F	Facility Hardesty Fundance. Annapolis,	eral Home, P.A.				
Physician	23a. Part 1. Enter the disease, ot complications that caused shock, or heart failure. List only one cause on each littlemediate Cause (Final disease or condition	d the death. Do not enter the mode of dying, such ne.	h as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death				
Examiner	/Medical resulting in death) Due to (or as a consequence of):							
sician and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as	Cause (Disease or injury that initiated events c.						
ਤੂਲ ਲੈ ਤੋਂ								
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the by Modical Contification (Contification Modical Contification IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year					
e law requires that the de has been signed by the le 2 should be detached	. Fait ii. Other significant conditions continuating to death t	out not resulting in the underlying cause given In F		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown				
The law re	Completed by		24a. Was an autopsy performed 1 □Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No				
s certification	© 25. Was case referred to medical examiner?	Othor	Place of Death (Check only one) ☐ Nursing Home 5☐ Residence	6 □Other (Specify)				
nding Phy		ury 28b. Time of 28c. Injury at	28d. Describe how in					
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	27. Manner of Death Natural 5 Pending (Month, Da	jury - At home, farm, street, factory, office tc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)				
ne Hospit n 24 hour he Funera pletely fill	29a. Certifier 1 Certifying Physician: To the best	of my knowledge, death occurred at the time, da of examination and/or investigation, in my opinior lated.						
Con With Co	29b. Signature and title of certifier	29c. License num D ~ A	BM9089194	Date signed (Month, Day, Year)				
10/BB	30-Name and address of person who completed cause of	25. Weens 85	- NW Z	1234				
State Registra	31. Date filed (Month, Day, Year) JUN 1 9 2008	rar's Signature						
DHMH 17 Rev 1/200	01							

	Please Type or Print in Black Indelibl					
	1 - State of Maryland / Department Certifica	nt of Health and te of Death		giene 2 (leg. No.	008 21787	
an al	1. Decedent's Name (First, Middle, Last) George J. Petrone		2. Date of Dea Month June	Day	Year 3. Time of Death	
er	4a. Facility Name (If not institution, give street and number) 4b. City	, Town, or Location of Dea		4c. Count		
		er Spring			tgomery	
	214-52-5245 1X M 2□ F 57 Yrs. Months	er 1 Year If Under 24 Hrs Days Hours Min		(, Year)	9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
Funeral Director		Spring			1 ☐ Yes 2 🗷 No	
Dire		ip Code			What Country?	
ral	2111 Fairland Rd. 20904			USA		
Fune	Armed Forces? If Yes, spo	edent of Hispanic Origin? (ecity Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	Bla	ace - American Indian, ack, White, etc.	
d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes	2 Specify:		Speci	_{fy:} White	
Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of w life. DO NOT (Secondary (0-12) College (1-4or 5+)	ork done during most of wo	rking	16b. Kind of E	Business/Industry	
E O	12 Logist	ics		Transp	ortation	
Bec	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle,	Maiden Surna	me)	
10	Nicholino Michael Petrone	Mar	tha Jane	Baldwi	n	
		ss (Street and Number or F Ave., Annapol			n, State, Zip Code)	
	1 🗆 Burlai 2 XX Cremation 3 🗀 Removal from State	isposition (Name of crematory or other place) Date 20c. Location - City or Town, State June 19 2008 Alexandria, Virg				
	21. Signatule of Funeral Service Licensee 22. Name a	and Address of Facility		Home	i uria, virginia Tnc.	
					pring.MD 20901	
	23a. Part 1. Em. r the disease, or complications that caused the leath. Do not enter the moshock, or neart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ode of dying, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
	resulting in death) Due to (or as a consequence of):					
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury					
Exan	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
	d					
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic 4 □ Pregnant at time of death 5 □ Other (standard or continuous)		ate of delivery Month Day Year			
든	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did to	bacco use cor	ntribute to the cause of death?	
d b	Acute Left Cerebellar Infarct		1 🗀 Y	es 2 🔀 No	3 ☐ Probably 4 ☐ Unknown	
Complete	-Acute Renal Failure		24a. Was a autop perfor 1 □ Yes	med?	. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	

Physician /Medical Examiner

d

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Event in a river by notified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician page 2 should be detached for use as the buriar

24a. Was an autopsy performed? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

31. Date filed (Month, Par Year)

3 Suicide

4 🗌 Homicide

5 Pending investigation 6 Could not be determined

Hospital: 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐Yes 2 ☐No

28d. Describe how injury occurred

29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and

29c. License number D63579

29d. Date signed (Month, Day, Year) June 19, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

asse of death (Item 23a) (Type, Print) Forest Glen Road, Silver Spring, MD 20910 Name and address of person who completed Maria Tayag, MD 1500

State Registrar

Be

Medical Certification: To

32. Registrar's Signature Enlise

After this

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 _ For State Certificate of Death

_			Registrar			or inical	011	Deam		Heg. No.		
	/sicia ledica	n	1. Decedent's Name (First, Middle, Last JOHN F •	PENTO	NY				2. Date of I Month June	Day 19 200		3. Time of Death 3:00 A
Exa	amine	er	4a. Facility Name (If not institution, give BERLIN NURSING &	· ·	ATION		BER	LIN			nty of Death RCEST	ER
Fund Direct			233-18-8498	x 7. Age M 2□ F	92 Y	Months	Days	If Under 24 Hours N	Hrs. 8. Date of E (Month, 1)	Day, Year)	Cour	lace (State or Foreign stry) VIRGINIA
and		- H	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
e Maryli	tified at	Director	MD WORCES	TER	BE	RLIN						1 ☑ Yes 2 ☐ No
Ē .o.	9		10e. Street and Number			10f. Zip	p Code			10g. Citizen	of What Cour	ntry?
ath w	inst	<u>a</u>	9715 HEALTHWAY DR				218				ED STA	
OIIY, OOIIII IOCE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or Items 23a or 28a-f show	xaminer n	by Fur	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates]	ever in U.S. No 942 – 1946	13. Was Dece If Yes, spe 1 ☐ Yes		lispanic Origin an, Mexican, P Specify:	? (Specify Yes or I Puerto Rican, etc.)		Race - Americ Black, White, cify: WH	etc.
2 hol	cal	ted	15. Decedent's Edi	ıcation	16a. I	ecedent's Usu	ual Occup	ation	Lungking	16b. Kind o	f Business/In	dustry
Taryland 21215-0036 2 should be filed within 72 hours aff and Mental Hygiene. Is marked other than "natural", or	the Med	Completed	(Specify only highest grad	College (1-4or 5		Give kind of wo life. DO NOT u SISTANT	use retired	d)	working	GI	ROCERY	
and 2 be filed that Hygins of other	ent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Midd	lle, Maiden Suri	name)	
ylancylancylancylancylancylancylancylanc	ic ev	2 B	WILLIAM PENTONY					IR	MA ASHBY			
Maryland ' Maryland ' nd 2 should be filed sith and Mental Hyg 27 Is marked othe	n n		19a. Informant's Name/Relationship (7	vpe. Print)	19b.	Mailing Address	s (Street	and Number of	or Rural Route Nur	nber, City or Tol	wn, State, Zip	Code)
M Mind 2 alith a alith a 27 Is	er tra		NANCY NEBIKER/STE	P DAUGHTE	R 32	716 E.	RIGA	DRIVE	, OCEAN V	JIEW, DE	E. 199	70
altimore, altimore, mit. Pages 1 ar partment of Hear	ry or othe		20a. Method of Disposition 1 ☐ Burel 2 to compation 3 ☐ 4 ☐ Donation 5 ☐ Ther (Specify		20b. Place of cemeters CAPE CRE	Disposition (Na crematory or HENLOPE MATORY	ame of other plac EN	^(ce) 6-	Date 20-2008		FORD,	own, State DELAWARE
Baltimore, Ma Baltimore, Ma permit. Pages 1 and 2s Department of Health at Important: if item 27 is	any inju		21. Signature of Funeral Service Light	-/-/					ERVICES, VIEW, DI	LTD E. 19970)	
Physic /Med Exami	ical		Immediate Cause (Final disease or condition resulting in death)	a. Ather	the death. Do note. **Cleotic a consequence of	e Caro			rdiac or respiratory			Approximate Interval Between Onser and Death
Ox 68760, th certificate be executed ending physician and		ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o							-
O. Box 68 he death certificative attending pl	ched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s		у		23d.	Date of deliv Month	ery Day Year
cords, P.O. B w requires that the deal been signed by the att	pe	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying	cause giv	ven in Part I.		d tobacco use o		he cause of death?
(0)	CI I	Completed							24a. W au pe 1∐ Ye	rformed?	4b. Were auto prior to co death? 1 □Yes	opsy findings available impletion of cause of
/ita	ctor,	Be (25. Was case referred to medical examiner?						f Death (Check on	y one)		
hysical his ca	dire	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		oatient 3 □ D		4/LINUIS	ing Home 5□R	esidence 6 🗆	Other (Speci	fy)
ion on andling Part.	e funera		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. T y Year) In	me of jury M	28c. Inju Wo 1 □	ryat rk?]Yes 2∐No		e how injury oc	curred	
Division or Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha	ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At home, far c. (Specify)	m, street, facto	ory, office			(Street and No Town, State)	umber or Rur	al Route Number,
e Hospita 124 hours e Funera	iletely fille	Medical C	29a. Certifier (Check only one) Certifying Ph	vsician: To the best niner: On the basis o and manner st	f examination and	death occurred or investigation	d at the ton, in my	ime, date and opinion, death	place, and due to to occurred at the tire	he cause(s) and ne, date and pla	d manner as a	stated. to the cause(s)
To th To th	comp	Me	29b. Signature and title of certifier	/	_	25	9c. Licen:	se number		29d. Date si	gned (Month	Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

AN 12+1

State Registrar

31. Date filed (Month, Day,

address of person who completed cause of death (Item 23a) (Type, Pri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 U U 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death SANDENS **Physician %**ear 1600 M MILY 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 32 Chesapeake Landing Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9/20/1919 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 😿 F 577-09-9278 88 Dakota Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis ns 23a or 28a-f sh must be notified Director 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 32 Chesapeake Landing 21401 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2€No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo White Completed by Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental 27 is marked c Axel Lindstrom Mabel Cooley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health sem 27 i Dennis Fry Son 114 Brick House Dr. Queenstown, MD 21658 Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 6/18/2008 baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause unisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No was a... autopsy performed? Yes 2 No has page 2 1□ Yes the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 Tyes 2 No 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. Signature and tale of certifier 29c. License number 29g. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

State Registrar JUN 1 9 2008

ame and address of person

32 (legistrar's Signature

o completed cause of death (Item 23a) (Type, Print)

Soul

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** MARY SCOTT JUNE 16, 11:10 PM Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hyattsville PRINCE GEORGES Sacred Heart Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Apr. 28, 1909 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 217 F Virginia 99 Director 224-32-9038 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director VA Greensville Skippers 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23879 5300 Moore's Ferry Road U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 ☐ Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Black Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) N.I.H. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Lab Technician 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augusta Clarke Vincent Alice Brown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3 8 7 9 19a. Informant's Name/Relationship (Type. Print) 5300 Moore's Ferry Road, Skippers, Herbert Scott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 6/19/08 Riverdale Pk Crem Riverdale, MD 4 ☐ Donatien 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Ineral Service Licent 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 days disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisuase of Light) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed and Due to (or as a consequence of): physician are the burial-t Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 I Inknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Severe Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Failure to Thrive page perform certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital of within 24 hours af To the Funeral D 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifier wowdly, my 6/19/08 D43121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 15216 Dino Drive, Burtonsviloe, MD 20866 Nural Chowdhury, 32. Registrar's Signature State Beer Registrar

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PERFECTO C. VALALAD, H.D.

2008

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32 Registrar's Signature

31. Date filed (Month, Day, Year)

1716 HARPORD Rd Su. 165 FALLS TON HO 21047

Patrick Crayton whedleton 08-04208 Ple

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 21792

	1- For State Certificate of Death Reg. No.	79
	Registrar 1. Decedent's Name (First, Middle,Last) PATRICK CLAYTON WHEEDLETON 2. Date of Death Month Day Year June 1, 2008 3. Time of Death 9915 hrs	
₹ ``	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cumberland 4c. County of Death Allegany	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD	
land f show any puce.	Usual Residence of Decedent 10a. State	
the Maryland 3a or 28a-f show otified at once.	5631 Galestown-Reliance RD 19973 United States	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Memal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 Yes 2X No specify: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No specify: 16. Was Decedent Ever in U.S. Armed Forces? 17. Yes 2 No specify: 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
5-0036 ed within 72 hours tygiene. other than "matury other than "matury Completed Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Tanner 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tanner Leather Produ	cts
21215-0036 build be filed within 72 Mental Hygiene. marked other than ic event, the Medical TO Be Comple	Elijah Leroy Wheedleton Nancy L. Owens	
MD 21 nd 2 should tith and Me m 27 is ma m aumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elijah L. Wheedleton/Father 5631 Galestown-Reliance Rd. Seaford, DE 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	_
altimore, mit. Pages l ar epartment of Hee portant: If ite jury or other tr	1 Burial 2 X Cremation 3 Removal from State A Donation 5 Other Specify: Mid Shore Cre.Ctr.6/6/2008 Cambridge, MD 22 Name and Address of Facility Mary Land	
	Framptom Funeral Home, PA, Federalsbur 133 Part Enter the disease or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart Approximate Internal Home (PA), Federalsbur	g terval
Physician /Medical `xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary artery thrombus complicating hypothermia Death Due to (or as a consequence of):	tand
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
60, e be executed ysician and burial - transit	UNPENDED AMENDED AM	
Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Fineral Director: After this certificate has been signed by the attending physheletely filled in by the fineral director, page 2 should be detached for use as the b dical Certification: To Be Completed by Physician/IMe	23b. Was decedent pregnant in the past 12 months? The live is the past 12 months? The live is the past 12 months? The live is the past 12 months? The live is the past 12 months?	ır
P.O. E	1 Yes 2 No 3 Probably 4 V Unkn	
of Vital Records, Ing Physician: The law requires that this certificate has been significate that the True of the Completed or: To Be Completed	24a. Was an autopsy findings available and autopsy performed? 1 Ves 2 No 1 Ves 2 1	
Vital Recysician: The Institute of the Company of t	25. Was case referred to medical examiner? Hospital: 4 Lengtion 2 EEP/Outpatient 3 DOA Other; Nursing Home 5 Residence 6 ✓ Other: Scene	
ion of Vit tending Physic eath. for: After this, the funeral dire	27 Manner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d, Describe how injury occurred	
Division o spital or Attending hours after death. Innertal Director: Afty yf filled in by the frame Certification:	Accident Accident Investigation Investigation Suicide Could not be determined Could	
Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by		
Me.	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 2, 2008	
	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 008 Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 3, 2008 1:06 PM James Glen Watts, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Oct 23, Washington, D.C. 1946 Director 213-44-3749 61 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County Yes 2 No Director Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 USA 1920 Gainsboro Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1964–68 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married 1 ☐Yes 2 No Şq Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Business Owner Windshield Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Glen Watts, Sr. Evelyn Opal Brake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 an Department of Healt. Important: If Item 27, any injury or other once. 1920 Gainsboro Road Rockville, MD 20851 Cynthia A. Watts/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State Chesapeake Crematory | 06/12/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** encephalopa thoxic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir DISAGER andjovasoulon Mynerose Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnan 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Mann o Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.0. ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the the discal Experiment must be notified at

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I Director: Af din by the fur

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1 and 2 should be filed within 72 hours after or Health and Mental Hygiene. Iem 27 Is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

requires that the death certificate be Division of Vital Records, or Attending

To the Hospital or Atte 3/0

FreVA

Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

D16360

Old GEORGETOWN Rd

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year) 06 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 9 Parc Jamue

Registrar's Signature JUN 2 0 2008

2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** WHITC Month Year ERUY 2/20 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 7518 Lemon Tree Ct. Hanover 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex 1 M 2 □ F **Funeral** Months Days Hours Min. 2/22/P1938 421-44-2498 72 ALDirector Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Expanirer must be notified at once. Director Hanover 1 ☐ Yes 24 X No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7518 Lemon Tree Ct. 21076 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 If Yes, Give 1958-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black δ Specify 3 Widowed 4 Divorced Year or Dates: 1982 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Supervisor NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Taylor Margaret Moore ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendoline White Hanover, MD 21076 7518 Lemon Tree Ct. Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 6/20/2008 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Naso disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of Artifler 29 Date signed (Month, Dav. Year) 29c. License number Name and address of person v a)se of death (Item 23a) (Type, Print) DEFENSE HIGHWAY ANNAPOUS N E 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 9 2000 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		State Registrar 1. Decedent's Name	ne (First Middle	e (ast)			C	ertificat	e or L	Jeath	1	2. Date of		No. 2	108	2 795
Physicia			Marie	Wahlen										2008	Year	12:05 A™
/Medic Examin		4a. Facility Name (/	If not institution	n, give street and r				June 17, 2008 4b. City, Town, or Location of Death 4c. Coun							y of Death	
				Nursing			4 5 1 41 . 4) If I lada	LaP1		r 24 Hrs.	1.5.5	D'. 41		Char	
Funeral Director		5. Social Security N 217-36-5	5411	6. Sex 1 ☐ M 2 🛣 F		70	ast birthda Yrs.	Months		Hours	Min.	8. Date of (Month)	$\stackrel{\text{Birth}}{1}, \stackrel{\text{Yea}}{1}$	937	Cot	nplace (State or Foreign untry) / land
land bw		Usual Residence of 10a. State	10b. County			10c. City	, Town or	Location								10d. Inside City Limits
leath with the Marylar ns 23a or 28a-f show must be notified at	tor	Maryland	Cha	arles				LaP1a	ta							1 X Yes 2 No
or 28.	Director	10e. Street and Nu		-				-	p Code				10g. (Citizen of	What Co	untry?
s 23a	eral	10200 La	ıPlata		andest F	iver in 116	r in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							U.S.A.		
after deat or Items 2	Funeral	11. Marital Status 1 □ Never Marr	ried 2□ Marr	Armed	Forces? S 2 💢 N	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							J. Race - American Indian, Black, White, etc.			
@ O H	þ	3 X Widowed	4 ☐ Divorced	If Yes, (Year or	Give Dates:			1 ☐ Yes	2 X No	Specify	<i>/</i> :			Speci	%: Whi	ite
"natu	letec	(Spec	15. Deceden	t's Education st grade complete	d)		16a. De (G.	cedent's Usu ve kind of we e. DO NOT u	ual Occupa ork done d	ation during mo	st of work	ing	16b.	. Kind of E	Business/I	Industry
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e filed al Hyg other vent, 1	Be C	17. Father's Name	(First, Middle,	Last)						18. Moth	ner's Nam	e (First, Mic	Idle, Maid	ien Surna	me)	
ould b Ments arked	2	George M					,	_			ie Br					
d 2 sh th and 7 Is m traum		19a. Informant's N						uling Addres								
tem 2	ŀ	Louis Mc		/Brother		20b. Pl	lace of Dis	Hawt sposition (Na trematory or	horne me of	e_Roa	ad, L	<u>.aPlat</u> _{Date}				0646 Town, State
Pages nent of nt: If I		1 🔀 Burial 2 4 ☐ Donation		3 □Removal fro Specify)	m State			rematory or		1	06/2	4/2008		helt.	enhar	n, Maryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; any injury or other traumatic event, the Medical Exagonce.		21. Signature of	nejal Syrvice	tcensee /	-11	_	171	22. Name a	nd Addres	s of Faci	lity	3035	01d	Wash	ninat	on Road
80F # 9		- Lay	MELL	selw	11							Wald	orf,	Mary	/lanc	1, 20601
O bservations		23a. Part1. Enter t shock, or hea Immediate Cause		only one cause or	n each lin	the death									İ	Approximate Interval Between Onset and Death
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uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying r injury	S Due 1	to (or as a	a consequ	uence of):	H	7~	10	AD.					Years
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rtificate be ng physici as the bu	dical	d														
eath certifi attending I for use as	Physician/Medica	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes,										23d. D	ate of del	ivery
death	sicia	in the past 12 1 ☐ Yes 2 i	2 months?		e birth egnant at			3∐Ectopic p 5 Other (s					_	N	onth	Day Year
s that the de ned by the s detached i		9 ☐ Unknowr Parl II. Other signi				ıt not resi	ulting in th	underlying	cause give	en in Part	1	23e I	Did tobaco	co use co	ntribute to	the cause of death?
w requires to been signer should be considered.	d by	Dia	betes	Mellit	us,	Per	-,74	eral c	1950.	u /a.	<i>y</i>					obably 4 Dunknown
The law requires that the death certificate be to has been signed by the attending physicial bage 2 should be detached for use as the bur	Completed	-	diseade	Mellit 2 , Lyp c Kidne	pert	دمع د	on,	CAD	GA	BL			Vas an	24b		utopsy findings available
	Com		Chroni	e Kidne	y d	1400	re					1 V	erformed	No.	death?	completion of cause of
sician certifi rector	Be	25. Was case reference examiner?		Hospital:					T Other	26. Plac	ce of Dea	th (Check o				
this d	n: To	27. Manner of Dea	ith	28a. Da	te of Injui	ry	28b. Tim	tient 3□D e of	28c. Injun Worl		Nursing H	ome 5 🗆 l				cify)
Attending F death. ctor: After y the funer	atio	1 ANatural 2 Accident	5 Pendir investi	gation	lonth, Day	rear)	Inju	M		Yes 2	□No					
or Att after de Direct in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	ained 20e. Pla	ace of inju ilding, etc	iry - At ho c. <i>(Specif</i>)	ome, farm,	street, facto	ry, office			28f. Locati City o	on (Street Town, S	t and Nun tate)	nber or Ru	ural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To Examiner: On the	the best of basis of anner sta	examina	wledge, d tion and/o	eath occurred r investigatio	d at the tin	ne, date a	and place eath occu	, and due to	the caus	e(s) and r and place	manner as e, and due	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature and		er, .				29	c. License							h, Day, Year)
				dun							614			Jun	e 17	,2008.
481		30. Name and add	ress of person	FFICE	ROA	eath (Item	23a) (Ty	pe, Print)	RS	MI	~w4.	~ 1				
Sta Registr		31. Date filed (Mor	nth, Day, Year)		egistra	ar's Signa	ture	parte	,							

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State of Maryland / Department of Health and Mental Hygiere 0 0 8 2 1 7 9 6

			For State Registrar	State of Maryla			of Health ar of Death	nd Mei		J. No.	O	21130
	Physici	an	1. Decedent's Name (First, Middle, Las	t)					Date of Death Month	5ªy 200	Year	3. Time of Death 7:15P M
	/Medic	al	ELIZABETH AKE 4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of		lancy	4c. County of		73
30%	E Admin	į.	KESWICK MULTI CA	RE		BALTIMORE				N/		
	Funeral		5. Social Security Number 6. S 190-12-5958	7. Age (In yr	s. last birthday) Yrs.				(Month, Day,)		Cour	
	Director □		Usual Residence of Decedent	00				2	/8/1922			SYLVANTA
	anylan ehow	_	10a. State 10b. County		City, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 X No
	the Ma	ecto	GA COLUMB:	[A	AUGUSTA	10f. Zip Co	nda.		100	g. Citizen of W	hat Cour	
	3a or	Dir	3713 MERION DRIVE	Ξ		3090			100	USA	nat oou	,
	ms 2	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceden	t of Hispanic Origi Cuban, Mexican,	in? (Specif	y Yes or No-		- Americ	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show early figury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 Yes 2X No If Yes, Give Year or Dates:		1 Yes 2			,		WHI	
21215-0036	2 hour	ted b	15. Decedent's Ed	ucation	16a. Dece	16a. Decedent's Usual Occupation			16	6b. Kind of Bu	siness/In	dustry
215	ithin 7. le. len "n	Completed	(Specify only highest gra	de completed) Coltege (1-4or 5+)	ATRCR	DO NOT use I	tone during most of etired) RTS PURCI	o <i>r working</i> HASER		CDONAL	D-DO	UGLAS
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and	ld be f ental h ked of	To Be	MARKO CUTURILO					KARA		20077 0077741110	-/	
Maryland	shou and M mar	۲	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (S	treet and Number	or Rural R	Poute Number,	City or Town,	State, Zip	Code)
	and 2 lealth m 27 i		mark kochevar/NEP			MERION			TA, GA	30907	T	Charles
Baltimore,	ages 1 nt of H : if ita		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispo cemetery, created TERBURG	matory or othe	r place)	Date		Oc. Location - (•	
	artmer ortant injury		4 □Donution 5 □ Other (S → c/f) 21. Sign tule of Funeral Service Licen	7	CEMETER	Y	Address of Facility	/11/2 THE 1		STERBU FUNERA		
å	Depariming Department of the partment of the p		Heath Ha	1 JAUNS11	120		H RAVEN I			N, MD	212	
			23a Part1. Enter the disease, or composition shock, or heart failure. List only					ardiac or re	espiratory arres	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. the sta	ge des	neates	U				,	Years
施	/Medical Examiner			Due to (or as a cons	equence of):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	equance of).							
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687	ificate g phys as the	edicai		. d								
XOX	th cert tendin rr use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy							d. Date of delivery Month Day Year	
P.O. Box	the at	ysici	in the past 12 morths? 1 □ Yes = 2 ⊡ No 9 □ Unknown	4☐Pregnant at time o 9☐Unknown		Other (speci				Moi	1111	Day Year
۳.	res that the death certif igned by the attending be detached for use a	by Physician/Me	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying caus	se given in Part I.	1	23e. Did toba	acco use contr	bute to t	he cause of death?
Division of Vital Records,	w requires been sign should be		Wiferexclerate	i heart di	sease,	histor	cy Chrqu	esteve	1 ☐ Yes	2 19 No	3 ☐ Prol	bably 4 Unknown
6 00	law re	Completed	heart feulure	, hortie	Atena	Les.			24a. Was an autopsy	24b. V	Vere auto	opsy lindings available impletion of cause of
<u>=</u>	ding Physician: The lav h. After this certificate hes funeral director, page 2		-						perform 1 Yes 2	ed?	eath?	2 □ No
\frac{1}{2}	siciar certif irector	o Be	25. Was case relerred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	C EP/Outpation	nt 3 DOA	Dther		Check only one 5 ☐ Resider		· (Case	4.1
סר	g Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?		d. Describe hov			(y)
Sior	eath. or: Aft	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 ☐ Yes 2 ☐ N	lo				
$\frac{3}{2}$	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, st cify)	reet, lactory, o	ffice	281	f. Location (Stre City or Town,		ar or Run	al Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	a C		ysician: To the best of my k								
	in 24 h	edical	(Check only 2 Medical Exam	niner: On the basis of exam and manner stated.	nation and/or in	vestigation, in	my opinion, death	h occurred	at the time, da	te and place, a	and due t	o the cause(s)
1	To To E	Σ	29b. Signature and title of certifier	ac freeze	~ ×		icense number			d. Date signed		
•			30. Name and address of person who				150>1			uly 6	1 24	V ()
	1		MILABELLE M.	regregia,	700 h	1-40 4	STREET	BI	ALTIMO,	RE, DO	21:	211
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Month Year Curtis Stanton Arnall July 2008 4b. City, Town, or Location of Death 4c. County of Death Adelphi 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. XXM 2□ F Months Days Hours Min. 63 Oct. 10, 1944 New York 10b. County 10c. City, Town or Location Adelphi Prince George's

1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Paint Branch Assisted Living Prince George's Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 218-42-7879 Director Usual Residence of Decedent filad within 72 hours after death with the Maryland nd Mental Hygiane. marked othar than "natural", or items 23a or 28a-f show imatic event, the Medical Examination or inside 10a. State 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3120 Powder Mill Road 20783 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. XYes 2 Yes, Give 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🖾 No Specify þ Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Social Security College (1-4or 5+) Computer Programmer Administration Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Haalth and Mental Curtis Carley Arnall ၉ Anne Wassel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is Lisa Marie Arnall/Daughter 10 Lafayette Place, Apt. 4, Burlington, VT Important: If Item 2 any Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pagas 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 7/8/2008 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD M01103 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one lause on each line. Approximate Interval Between Onset and Death Immediate Car Final disease or condition resulting in death) Physician Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Non small cell cancer of the lungs w/metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the daath certificate be executed burial-transit High cholesterol and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) s been signed by the should be datached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension (CAD), DVT, Alcohol Abuse, Heavy chain XYes 2 No 3 Probably 4 Unknown smoker, Schizophrenia, Bipolar disorder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 s After this certificate has autopsy perform 27 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one) Group Hospital Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Home 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea. al Director: Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide ō Hospital To the Hospital within 24 hours a To the Funaral I **XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D47838 JUly 7, 2008

Ö ۵. Records. Vital ō Division

Naomi 31. Date filed (Month, Day, Year) State 0 JUL Registrar

30. Name and address of person who comp

Ihedioha,

MD

2008 8

Registrar's Signature

sted cause of death (Item 23a) (Type, Print)

6201 Greenbelt Road, U7

College Park, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1938 PM Juanita 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1 □ M 2 Months Days Hours Min 219-26-2535 Nov. 22, 1938 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d Inside City Limits MD Baltimore 1 Xyes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4404 Moravia Road Apt. 4 21206 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify African American 1 ∐Yes 2.15MNo Specify 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) claims examiner TWUF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Figg Gertrude Loker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Allen / Son Apt. 4; Baltimore, Maryland 21206 4404 Moravia Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 07/09/2008 Baltimore, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 23a Part 1 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 hours or as a consequence of): Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**0 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Examiner the death certificate be executed P.O. Box 68760, Division of Vital Records. To the Hospital or Attending Physician:

Examine burial-transit and A physician Physician/Medical the as the attending use P detached signed by be this certificate has been After death after

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Exp. of the most be rediffed at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. The last to other

Physician

/Medical

within 24 hours

To the Funeral Director	completely filled in by the
•	h

à Completed Be 2 Certification: Medical

29b. Signature and title of certifier

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramin Herafi, MD 4940 Easter r

2008

Avenue, Baltimore, MD, 21224 Eastern

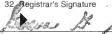
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 0 8

4 Homicide

(Check only one)

29a. Certifier



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle Last, 2. Date of Death Physician Month 0327 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Baltemore Bunard Security Number 7. Age (In yrs. last birthday) Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 M 2 □ F Hours Director Usual Residence of Decedent the Maryland 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Mudical Exercities must be notified at Director 1 XYes 2 □ No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral items 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 No þ Specify Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) eachel nt of Health and Mental Hygis If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) loore Informant's Name/Relationship (Type. Price) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11334 Fairtax, b. Unit 103 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 permit. Page Department o important: If any injury or 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State treenmount 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee treen Funera Services 22. Name and Address of Facility Vaugh ctsatto. Md. 21229 Baltimorre 23a. Part1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Gastric disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bowe Schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of): requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should COPD 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an autopsy certificate 2 **X**No 2 **1** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28h. Time of After 28d. Describe how injury occurred or Attending 1 Matural 5 Pending (Month, Day, Year) 2 Accident investigation 1 ☐ Yes 2 No after death filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055119 MD s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Houns GENULT, MI) SINM HOSPITA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien $\stackrel{2}{2}008$ 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9:45AM **Physician** nge CZ 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner izabeth -imore Center VINSING a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number Funeral Months Days 213-14-9638 1 □ M 2 🗷 F MARYLAND Yrs. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumatic event, the Medical Exert Interrocate by notified at enne 1 XYes 2 □ No Britimere MD Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1248 2122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Ite 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 IUrca 050 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sent Heights 1248 Pine to RZECZKO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Trun, State Date 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 40 7-11-2008 4 ☐ Donation 5 ☐ Other (Specify) OF HAITA of Funeral Service Lic 22. Name and Address of Faci 21. Signature KAL ANNINO 213 Balto st. 21224 conkling Approximate Interval Between Onset and Death conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final emen 76 -earl Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) mellitui Examiner ab ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sonsequence of) Examiner attending physician and for use as the burial-transit RAVI that initiated events resulting in death) Last Due to (or as a conseque ce f) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) been signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by brilla 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy 2 XN0 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending 1 Natural 2 Accident 1 🗌 Yes 2 🗌 No investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

completely filled in by the funeral director, after death. 24 hours

> State Registrar

Medical

4 \ Homicide

29a. Certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 3320 enue

determined

Benson

32. Registrar's Signature

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mendoza Berroya Amelia Day 2008 **Physician** /Medical 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner 7814 Baltimore Kolling Vista loth na ham Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 ️ F Director hillipines Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a firediction in the resulting and injury or other traumatic event, it is firediction. 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Notting BALTI MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA D 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Tilipino 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 70VERNMEN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mendoza ျှ 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) OUR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State anstanceal Cha FOREST 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Rivered Che nota 23a. Part 1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardilic or respiratory arrest shock, or heart failure. List only one cause on cuch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? Yes 2 No 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mchirit DO06494 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person laryland Ave Baltimore MD 21218 Mobiuddin MID

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 July Physician Tricia Brooke Bowley 8:02 Рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, AUG 25, 9. Birthplace (State or Foreign Country)
Colorado 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 ▼ F 576-06-4895 37 1970 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time ZT is amended other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan or must be notified at 10a State MD Baltimore Towson 1 □Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 38 Acorn Circle, Apt 101 21286 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White à Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cystic Fibrosis Elementary/Secondary (0-12) College (1-4or 5+) Event Coordinator Foundation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Bowley Linda Waiting ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeffrey Bennett Carlson/husband 38 Acorn Circle, Apt 101 Towson, MD 21286 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 17/5/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 1. Toll 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OMPLICATIONS OF (FIBR OSIS Physician PONC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Hospital or Attending PhysIclan: The law requires that the death certificate be execut burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a detached i 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ≥√ No 3 Probably 4 Unknown 1 🗆 Yes funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Margaret 2008 Delia Boswell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hor Bel A: Bel Air Health & Rehabilitation Centur If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20, 1912 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours Maryland 1 □ M 2 🗙 F 96 220-12-7640 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Forest Hill Maryland Harford Co. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21050 1 Colgate Drive death v Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 💢 No Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examines 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White It Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Droll George H. Linzey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Abingdon, Maryland Mr. Donald M. Boswell / Son 3305 Marsh Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Gardens of Faith Cem. 7/10/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Michael E. Canapp Baltimore, MD 21214 LEONARD J. RUCK, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years seme **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner and burial-transit Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be execut Due to (or as a consequence of): physician Physician/Medical use as the IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 0 5 ☐ Other (specify) 4□Pregnant at time of death detached 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s 1∏ Yes 2**X** No 26. Place of Death (Check only one) 25 Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident Injury 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Vargaret

State

Medical

and manner stated

29c. License number D56545

WV

BEL AIR

29d. Date signed (Month, Day, Year) 108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

206 HAYS ST #102 SHILPI KHOSLA

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere 008 21804 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:18 PM Year **Physician** 3 0 2008 John Bright JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMOFE SAINT AGNES HEALTHCARE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) UNK 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**√2**M 2□ F Months 47 158-58-6665 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State 28a-f ahow rai', or itema 23a or 28a-f ahov Examinan must be notified at Yes 2 No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5947 St. Mary Street 21207 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1-Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify White Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 'naturai' 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working this life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic avent, once. 17. Father's Name (First, Middle, Last) unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3318 Kerry Road; Baltimore, Maryland 21207 April M. Chambers / Care Provider Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 D€remation 3 ☐ Removal from State 07/02/2008 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION UNKNOWN Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): an/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No certificate or Attending Physician: 26. Place of Death | Check only one | Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ 10 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Division 1 Matural 5 Pending 1 Tyes 2 No death. 2 Accident investigation Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of partifier DU051865 JULY, 12008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST AGNRS ROSPITM BALTIMORE, MD CNRTIS HARLRS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 8 2008 Colores Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere 0 0 8

21805

			1 - For State Registrar	State of Maryland	d / Department of Certificate		Mental Hyglet Reg. I		21000
	Physic /Medi		1. Decement's Name (First Middle, La	I'm Carter			2. Date of Death Month	2007	3. Time of Death 3. 1623 PM
	Exami		4a Faglity Name (If not institution, give	ve street and number)	4b. City, Tov	wn, or Location of Death		4c. County of Deat	th
	Funeral Director		5. Social Security Number 6.3 217-66-8054 Usual Residence of Decedent	Sex 7. Age (In yrs. I	Yrs. It Under 1 Y		8. Date of Birth Worth, Day, Ye	9. Bird	thplace (State or Foreign buntry)
	aryland ehow	2	10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits 1 ¥Yes 2 □ No
	th the M or 28a-f	Funeral Director	10e. Street and Number	1. 1.	10f. Zip Co	ode	10g.	Citizen of What Co	
	death wi	eral [514 Norman	12 Was Decedent Ever in II		1 229 t of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame	
	ING 21215-0036 be filed within 72 hours after death with the Maryland hat Hygiene. d other then "natural", or tleme 23a or 28a-f show event, the Modical Exertinative rodiling at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 □ Yes 20	No Specify:		Black, Whit	Black
	Baltimore, Maryland 21215-0036 semit. Pages I and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural", or ny hijury or other traumatic event, tra Modical Exert price.	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5+)	A life. DO NO use I	done during most of wor	rking 16b	Kind of Business	III +
	laryland 2121 2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, the M.	3e Cor	17. Father's Name (First, Middle, Las	الإد	HSSEM bly	18. Mother's Nar	ne (First, Middle, Maid		Harl
	iryiai should b nd Menta marked marked	To Be	James Gar- 19a, Informant's Name/Religionship	ter	19b. Mailing Address (S	treet and Number or Ru	Willia Iral Boute Number, Cit		Zip Code)
	IOCE, Maryla ges 1 and 2 should the of Health and Men if item 27 is marke or other traumatic		Erica Carter	(Daughter)	1.1	shoe Ave.	Baltime	Location - City or	21218
	Pages in ment of the next of the next of the next of the next it its		20a. Method of Disposition 1	Demoval from State	emetery, crematory or other	ark 7.	11.08 7	Baltin	ore, mo
ı	Baltimore, Mi permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra		21. Signature of Funeral Service Lice	1. Kreene	22 Valig 5151 B	alto. Nat	ene fun	1eral 5 (21229	ervices
	8		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that caused the death y one cause on each line.	h. Do not enter the mode o	of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	uence of):				MINCHIOVOFI
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequ	uence of):				
+	ficate be executed physicien end is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):				
	68760, tificate be e. 19 physicien as the buria	edical		d					
	BOX (Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	I death 3 Ectopic pregi			23d. Date of de Month	olivery Day Year
	Cords, P.O. I w requires that the de been signed by the e should be detached f	5	Part II. Other significant conditions	contributing to death but not rest	ulting in the underlying caus	se given in Part I.		co use contribute t	o the cause of death?
Parc	Records, The law requires t the has been signe bage 2 should be o	Completed					24a. Was an autopsy performed 1 Yes 2	death?	utopsy findings available completion of cause of
2	Vital sicien: T s certificate lirector, pa	o Be C	25. Was case referred to medical examiner?	Hospital:	500	Othor	ath Check only one		
7.	ing Physical distributed distr	I	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		Injury at Work?	dome 5 ☐ Residence 28d. Describe how i		эсігу)
Ca	Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not 4 Homicide determine	be as Blace of Lainer As he	ome, farm, street, factory, o	1 Yes 2 No	28f. Location (Stree City or Town, S		Rural Route Number,
	Spitel o hours aft ineral Di y filled ir		29a. Certifier 1 Certifying P	hyskalan: To the best of my kno	wladge, daeth corumad at	the time, date and place	a and due to the naun	e(s) and manner a	is stread
	the Ho thin 24 I the Fu	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	miner: On the basis of examina and manner stated.		i my opinion, death occi		and place, and du Date signed (Mon	
	F ¥ F 8			\sim \geq		62862	J	uly 5, 2	2008
	8		30. Name and address of person who	completed cause of death (Item 960 Ca	n 23a) (Type, Print)	Battim	oreim.	0 212	29
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Signa	Aprile				•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM#19b, perfil G881,7/8/09,WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John C. Clemens 2008 July 3 2:10 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lorien Taneytown Nursing & Rehab. Ctr. Taneytown Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 11X M 2 □ F 219-18-6848 82 Director Feb. 9, 1926 Balt., Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Baltimore Glen Arm 1 TYes XINO Maryland Director death with the 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States 11630 Glen Arm Road 21057 of America Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" -- " any injury or other traumatic event." 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1⊉∏Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No 1 ☐ Yes 2XXXIIo Specify: Specify: Completed by white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Clemens Caroline Etzkorn 10 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Lauren Hill Court Reisterstown, Maryland 21136 Jean Meconi/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Meinorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State July 2008 8, **‡**□ Burial 2 □ Cremation 3 □ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bucks disease or condition resulting in death) wmme /Medical Due to (or as a consequence of) Examiner defpude Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 687607 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation ours after death.

neral Director; Af
filled in by the fur M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 连 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ada cl 31. Date file State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) o Month Day Year 30 3 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE REHABILITATION & EXTEN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days 1₩ M 2□ F Months Hours Min 90 138-10-2438 1/3/1918 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Baltimore Cockeysville 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 5 Warren Lodge Court 21030 of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2₺₺®o Specify white 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electric Vehicles Director of Marketing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alan Reissman Marjorie Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara A. Moore/ companion 5 Warren Lodge Court Cockeysville, Maryland 21030 Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Evans Funeral Chapel – Bel Air 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State July 2008 6, 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Peacerul ATUSTIBLIVES Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Fineral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SQUAMOUS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy

Physician /Medical Examiner

Department of Health a Important: If Item 27 Is any Injury or other trains

Physician

/Medical

Examiner

10a. State

Funeral

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

"natural", or

and Mental Hygiene. Is marked other than

the Medical

within 72 hours after death

filed

Pages 1

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Examiner Physician/Medical þ Completed

Be

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Certification:

Medical

physician s the burial as for use signed by the a d be detached f peen certificate has page funeral director, After this To the Hospins.

within 24 hours after death.

To the Funeral Director: Aft

P.O.

Records,

Division or Vital

or Attending

Hospital

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No

1□ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural 2 Accident

(Check only one)

29a. Certifier

5 Pending investigation

28a. Date of Injury (Month, Day Year)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

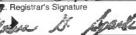
29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D24648 07-03-2008 CHRAVEN BLVD BALTIHGE MD 3900 CO 31. Date filed (Month, Day, Year)

Registrar

0 8 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17:58 PM July Janis В. Cooper /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Hospital aty of Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F Days Hours 74 Director 227-50-9929 NC May 31, 1934 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show Department of Health and Mental Hygiene. Important; if items 23a or 28a-f show amy Injury or other traumatic event, if *Modical Exaction and to subfield any plury or other traumatic event, if *Modical Exaction and to subfield and poops. 1 Tyes 217 No Director MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12613 Gores Mill Road 21136 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: <u>ک</u> 3 N Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education 5 +Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Arthur Booth Stevens Elsie Leary ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Blair Wayne Cooper Son 199 Woodbury Road Woodbury, NY 11797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Leary Fam Cemetery 7/9/08 Gregory, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumoustis Carinii Pheumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner chronic steriod use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner rung disease, meumatic etiology 8 months be executed and burial-tran attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten detached for us 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atherosclerotic Coronary agery Disease page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Polymyalgia rheumatica certificate 1 ☐ Yes 2 🔽 🗸 0 1 Tyes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Division of Vital Records, Hospital or Attending Physician: The 24 hours a To the within 2

P.O. Box 68760,

Baltimore, Maryland 21215-0036

Known

Datient

State Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 5,2008

o completed cause of death (Item 23a) (Type, Print) rson W 30. Name and address of

Sinai Houpital of Baltimore MD

32. Registrar's Signature 31. Date filed (Month, Day, Year)

08-04996 Patricia Cale Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

atricia Cale		State of Maryland / Department of Certificate of	-	rgiene 2008 21	80				
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death	Ť				
edical Exami		Patricia Ann Cale	b. City, Town, or Location of Death	June 28, 2008					
		4a. Facility Name (if not institution, give street and number) St. Joseph Medical Center	Towson	Baltimore County					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Foreign					
Director		573-76-4949 1 M 2 XF 64 Yrs.	, ,	4-20-1944 Country) OK					
any	Ì	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on	10d. Inside City L	_				
Maryland 28a-f show d at once.	ъ	OK Muskogee Muskog		1 X Yes 2	No				
, MD 21215-0036 [7.43] and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. team 27 is marked other than "natural", or items 23a or 28a-f sho transmatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
with the	a D	3504 River Oaks 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	74403 s Decedent of Hispanic Origin? (Sp						
death v	nue	1 Never Married 2 X Married Armed Forces? If Ye 1 Yes 2 X No	es, specify Cuban, Mexican, Puerto						
after ral", o	by F	or Dates:	Yes 2 No specify: 's Usual Occupation (Give kind of w	Specify.White work done 116b. Kind of Business/Industry					
2 hours a "natura I Examir	sted		ost of working life. DO NOT use retir						
5-0036 led within 72 Hygiene. other than *	Completed		memaker	Own Home					
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica		17. Father's Name (First, Middle, Last) Armel Houston Walden		e (First, Middle, Maiden Surname)					
2121 suld be fil Mental I marked c event,	To Be			e Watkins Rural Route Number, City or Town, State, Zip Code)					
and 2 shotell the shotell shot	٦	William Lynn Cale-Husband 3504							
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		1 X Burial 2 Cremation 3 Removal from State crematory or oth		Date 20c. Location - City or Town, State					
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify.	11 Cemetery 7-						
Ball permit Depar Impo injury		21. Signature of Eugeral Service Licensee 22. N	ome, PA, 2134	cadley-Ashton Funeral Willow Spring Road, 212	222				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as cardiac o	or respiratory arrest, shock, or heart Approximate In Between Onse	nterval				
Medical xaminer		Immediate Cause (Final disease a. Complication of surge	ery for flat bac	k syndrome Death					
, -		or condition resulting in death) Due to (or as a consequence of):							
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
, -	xaminer	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
executed an and al - transit	al Ex	d. 23a,PII,27,pe	rME, g884 10/15/	'08 TT					
ਜ਼ਿਜ਼ ਫੇ	ledical	X UNPENDED AMENDED 23a, P11, 27, pe		23d. Date of delivery					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	siclan/M	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pregna		ar				
OX 6 eath ce attend for use	sick	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Ot	her (Specify)						
O. B at the d lby the	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deal					
S, P.O ires that t signed by d be detac	d by	Atherosclerotic cardiovascular dise	ase	1 Yes 2 No 3 Probably 4 Unkr					
ords w requas been should	plete			24a. Was an autopsy performed? 24b. Were autopsy findings av prior to completion of cau death?					
Records, The law requir ficate has been s	Completed			1 ✓ Yes 2 No 1 ✓ Yes 2	No				
ital Rec	Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other Nursin	ing Home 5 Residence 6 Other:					
of Vital ng Physician After this certi	: To	27. Manner of Death 28a. Date of Injury 28b. Time of I		28d. Describe how injury occurred					
ion tendin eath. tor: A the fur	atior	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No						
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree	et, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number or Town, State)	er, City				
To the Hospital within 24 hours To the Funeral completely filled		4 Homicide determined (Specify) 29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occur	erod at the time, date and place, and	d due to the cause(s) and manner as stated					
the H thin 24 the F mpletel	Medical	one) 2 Medical Examiner: On the basis of examination and/or investiga	tion, in my opinion, death occurred	at the time, date and place, and due to the cause(s)					
7 × 5	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
		Theodore M. Wie TR. M. A	O.C.M.E. OCH	ME June 29, 2008					
R		30. Name and address of person who completed cate of death (Mem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimor	re, MD 21201					
9	tate	21 Date filed (Month Day Year) 32 Enjetrar's Signature	· · · · · · · · · · · · · · · · · · ·						
Regis		JUL 0 8 2008 Server 1	West -						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day **Physician** 4, 2008 Clark 5:52 Margery Marston /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Linthicum Anne Arundel Chesapeake Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 578-34-0060 OCT 30. 1926 Director Kansas Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mcdcal Evention that be retified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No Funeral Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 Harborview Drive 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 ☐ Widowed 4 X Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) <u>Librarian</u> Housing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Fisher Henry Marston ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shelley Marston Clark/Daughter 359 E. 62nd St, Apt 6F NY, NY 10065 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc 7/5/08 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 110 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burlal-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 24 hours after death.

9 Funeral Director: After this certificate has been signed by the letely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 2 No 1 ☐ Yes 05014 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number eted cause of death (Item 23a) (Type, Print)

State

Registrar

(Month, Day, Year)

0 8 2008

2. Registrar's Signature

			State of Maryland / D	epartment of Health and Certificate of Death	d Mental Hygier Reg. ۱	2008 21811
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		DOROTHY SANDS CHILDS		JULY	6. 2008 9:25P M
£	Examin	er	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of De		Ac. County of Death Baltimore
and .	Formul		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 H		
	Funeral Director			Yrs. Months Days Hours M	ns. 8. Date of Birth (Month, Day, Yea OCT. 11, 1	919 Maryland
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	/laryla f sho	ō	Maryland Baltimore Towso			1 ☐ Yes 2√√No
	r 28a-	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th with	ralD	800 Southerly Road #702	21286		USA
21215-0036	within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Exacultar must be codified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Foxos? 1 ☐ Yes № № No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □Yes 2★No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
ည် က	72 ho	eted	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of ville. DO NOT use retired)		Kind of Business/Industry
121	within sne.	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	omemaker		Own Home
	ıt He	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's N	lame (First, Middle, Maid	en Surname)
lan	W	To B	William Harvey Sands			npson
	C1 10			Mailing Address (Street and Number or Sansbury Road Fr		
w	s 1 and of Health item 27 other to		20a. Method of Disposition 20b. Place of	Disposition (Name of y, crematory or other place)		Location - City or Town, State
<u>E</u>	Page ment c ant: If ury or	-		ount Crematory July	/ 8,2008 Ba	ltimore, Maryland
Baltimore,	permit. Pages: Department of I Important: If ite any Injury or of		21 lignature of Funeral price Licensee XMM	6500 York Ro	oad Baltimor	e, Maryland 21212
			23a. Part 1. Enter the disea (4, or complications hat caused the death. Do n shock, or heart failure. List only one, ause on each line.	not enter the mode of dying, such as care	diac or respiratory arrest,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY For the substitution of th			
	Examiner		SEPSIS SYNDRO			
Ļ	- H	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):		
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68/	tificate ig phy as the	ledic	V		-	
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as!	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
٠ <u>.</u>	s that the de ned by the a detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the cause of death?
ğ	w requires been sign should be	ed b			1 Tes	2 No 3 Probably 4 Unknown
al Records,	siclan: The law r certificate has be irector, page 2 sh	Completed			— 24a. Was an autopsy performed 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1
Vital	siclan certifi rector,	Be	25. Was case referred to medical examiner?	Other	Death (Check only one)	- 6 FlOther (Creeify)
ō	this ald	n: To		Time of 28c. Injury at	g Home 5 Residence 28d. Describe how i	
o	ath. rr: Afte	atio	2 Accident investigation	njury Work? M 1 ☐ Yes 2 ☐ No		
Division of	or Atte after de Directo in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge and manner stated.	e, death occurred at the time, date and p nd/or investigation, in my opinion, death o	lace, and due to the caus occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	/		A. J. Heloy, M. A	. D 17695	J	uly 6, 2008
	15		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		(ITC)
	Sta	ate	ABDALAH J. HE OL M. D. 76/21 C 31. Date filed (Month, Day, Year) 32. Registrar's Signature	SLER DRIVE TOWS	ON MARYLA	ND 21244
	Regist	rar	111 0 8 2008 Reserve	bout		

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04831 State of Maryland / Department of Health and Mental Hygiene Gerald Hugh Davis 2008 21813 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1230 hrs June 23, 2008 Examiner Mer Gerald Hugh Davis 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton 7851 Malcolm Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours Months Country) MD APR 21 1944 Director 64 578-56-9896 1 **X** M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 0b. County 1 Yes 2 X No Clinton Prince George or items 23a or 28a-f show must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 20735 7002 Vismanco Lane 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 2 X No Yes Specify: White 4 X Divorced If Yes, Give Year Yes 2 X No specify: 16b. Kind of Business/Industry <u>გ</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Tile & Marble Setter Construction 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beech Ruth Harry Davis, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ٩ Harry Davis, Jr. - brother 7002 Vismanco Lane, Clinton, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/3/2008 Baltimore, MD Metro Crematory, Inc. 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses.

22. Name and Address of Facility.

Cremation Society of Maryland, Ir 299 Frederick Road, Baltimore, M

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and `ካysician failure. List only one cause on each line. Death ledical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease _kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Universitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and tran Physician/Medical **AMENDED** physician a UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 Unknown <u>8</u> of Vital Records, P. Chronic Alcohol Use 24b. Were autopsy findings available Completed 24a. Was an page 2 should prior to completion of cause of certificate has been autopsy performed? death? 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be Other₄ Nursing Home 5 Residence 6 Other: Scene Hospital: 1 examiner? ER/Outpatient 3 DOA Inpatient 2 this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury neral Director: After t filled in by the funeral 27. Manner of Death 1 Yes 2 No 1 V Natural Division Pending Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 6 Could not be Suicide Certif determined To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 24, 2008 O.C.M.E. me 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2008 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 5:15 Am **Physician** John George Edelmann 5, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkville Baltimore Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/22/1916 Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days 1**∑**M 2□F 92 216-03-8275 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10b Count item 27 is marked other than "natural", or Itama 23a or 28a-1 show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No by Funeral Director MD Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8830 Walther Blvd. Apt. 009 21234 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Edelman, Joh Time of Death Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Printer/ Educator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Henry Edelmann Theresa Mielke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 905 Army Road Ruxton, MD 21204 Joan Craig/ Daughter Baltimore. 20b. Place of Disposition (Name of cometery, crematory or other place)
Evans Funeral Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If its eny injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/09/08 Forest Hill, MD 4 □ Donation 5 □ Other (Specify) Chapel- Bel Air 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Dialated Cardiomyupeshy Physician /Medical Due to (or as a consequence of) Examiner Uninary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine (ingestive lbul Libre Division of Vital Records, P.O. Box 68760, burial-tran Due to (or as a consequence of) physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year ō 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. À page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificete 21 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes o the Hospitel or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Corrlying Physician: To the best of my knowledge, death occurred at the time, data and slane, and due to the name (s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 27a: Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of artifie H0052365 completed cause of death (Item 23a) (Type, Print) Parkville Maryland 21234 6/ 30. Name and address of 8800 Walther Boulovard 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 8 2008 Sparke Registrar

DHMH 17 Rev 1/2001

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			1 - State Registrar Ce	rtificate of Death	Reg. No. 2008 21815					
	Physic		1. Decedent's Name (First, Middle, Last) Antoinette M. Ewers	Mont						
4	/Medi Examii		4a. Facility Name (If not institution, give street and number) Heritage Harbor Health & Rehab	July 1, 2008 10:45p ^M 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel						
	Funeral Director		5. Social Security Number 6. Sex 131–36–9982 1 D M 2 F 97 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. 04/	of Birth 9. Birthplace (State or Foreign Country) NY					
	e Maryland sa-f show inted at	ctor	Usual Residence of Decedent 10a. State	Annapolis	10d. Inside City Limits 1 ⊠ Yes 2 □ No					
	th with th	Funeral Director	305 Eatons Landing Drive	10f. Zip Code 21401	10g. Citizen of What Country? USA					
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Married 1 Never Married 2 Married 1 Never Married 3 Married 1 Never Married 4 Married 1 Never Married 2 Married 1 Never Married 3 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 4 Married 1 Never Married 5 Married 1 Never Married 5 Married 1 Never Married 6 Married 1 Never Married 8 Married 1 Never Married 8 Married 8 Married 1 Never Married 8 M	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 □ Yes 2 ☎ No Specify:	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: White					
Baltimore, Maryland 21215-0036	within 72 h iene. than "natu ne Moicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home					
land 2	2 should be filed vand Mental Hygir is marked other raumatic event, it	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M Antoinette	liddle, Maiden Surname)					
, Mary	1 and 2 shou Health and N tem 27 is ma	_	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Rural Route 1 5 Eatons Landing Drive						
imore			4 Donation 5 Other (Specify) St. Andre	psition (Name of pate place) ew Cemetery 07/10/20	_					
Balt	permit. Page Department (Important: If any injury or once.		21. Signature of Euneral Service Licensee Dorota W. Marshal &	2. Name and Address of Facility Charles L. Stevens F 1501 East Fort Avenu	Funeral Home Inc. de, Baltimore, MD 21230					
	Care be executed his physician and his physician and as the burlal-transit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to infinite diatecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		tory arrest, Approximate Interval Between Onset and Death					
O. Box	death ce e attendi d for use	Physician/Medical		□ Ectopic pregnancy □ Other <i>(specify)</i>	23d. Date of delivery Month Day Year					
rds, P.	law requires that the de as been signed by the a 2 should be detached f	ģ	Part II. Other significant conditions contributing to death but not resulting in the u		Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown					
of Vital Records,	The ate h	Be Completed	25. Was case referred to medical	- 1	Was an autopsy findings available prior to completion of cause of death? yes 2 □ No 1 □ Yes 2 □ No					
sion of V	Attending Physician: The lav r death. ector: After this certificate has by the funeral director, page 2	Certification: To B	examiner? 1 Yes 2 XNo	Other: 41X Nursing Home 5	Residence 6 Other (Specify) cribe how injury occurred					
	후류		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Locat City of	ion (Street and Number or Rural Route Number, or Town, State)					
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, deat 2 ★ Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)					
	To vit		29b. Signature and title of certifier	29c. License number D 00 40519	29d. Date signed (Month, Day, Year)					
	b		30. Name and address of person who completed cause of death (Item 23a) (Type, Mirza M. Nusairee, M.D. 1667 Crofto	n Centre, Suite 1, Cro	ofton, MD 21114					
	Sta Registra	ie ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	E Company						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2008 21816 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Year JULY SIDNEY **ENGLANDER** 4 1:50 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min. 169-14-4458 85 05/31/1923 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6605 PARK HEIGHTS AVENUE, APT. D-1 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ZYes 2 No WWII 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1,4or 5+) Elementary/Secondary (0-12) ELECTRICAL ENGINEER US NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PHILIP **ENGLANDER** ROSE MOSKOWITZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDITH ENGLANDER / WIFE 6605 PARK HEIGHTS AVE., APT. D-1, BALTIMORE, MD 21215 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date CHEVRÁ AHAVAS CHESED 07/04/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & EROS., INC. 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final failure congestive Heurt yeurs disease or condition resulting in death) Due to (or as a consequence of): heart disease wears 15 chemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

10a, State

MD

Director

Funeral

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Be Completed

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Funeral

Director

Show

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho, any injury or other traumatic event, the Medical Examinar must be mortified.

Baltimore, Maryland 21215-0036

Pages '

death with the Maryland

attending physician and for use as the burial-tran signed by t the detach

Physician/Medical

þ

Be Completed

Medical Certification: To

law requires that the death certificate be execute P.O. Box 68760 Records, Hospital or Attending Physician;

within 24 hours after death

To the Funeral Director:
completely filled in by the f 10

In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy her (specify)		Month Day Year
chronic asstr	contributing to death but not resulting in the under	lying cause given in Part I.		o use contribute to the cause of death?
	sphagia with Chronic As	t i	24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	B DOA Other: 4 Nursing H	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	""	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not be determined		factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place igation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. D	Pate signed (Month, Day, Year)
mour		030377	8	uly 4, 2008

Registrar DHMH 17 Rev 1/2001

State

BALTIMORE

MD

21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue

32. Registrar's Signature

HE164ts

PARK

JUL 0 8 2008

31. Date filed (Month, Day, Year)

08-05128 Samuel Fullard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

samuel Fullard		State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No. 2008 2181
Physicia: Medical Examin	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year OQ25 bro
vieulcai Examini		Samuel Fullard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		1915 North Longwood Street Baltimore
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F 56 Yrs. 7. Age (In yrs. last birthday) Months Days Hours Min. 1 X M 2 F 56 Yrs. 1 X M 2 F 57 Yrs. 1 X M 2 F 57 Yrs. 1 X M 2 F 57 Yrs. 1
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Aaryland 28a-f show Latones.	ē	Maryland Baltimore 1 X Yes 2 No
r death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1915 North Longwood Street 21216 U.S.A.
th with the ems 23a	교	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
er death	Funeral	Never Married 2 X Married 1 Yes 2 X No
urs afte	ᅀ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
16 n 72 ho tan "na ical Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+)
17215-0036 Id be filed within 72 hours after featal Hygiene. narked other than "natural", event, the Medical Examiner.	Completed	12 Warehouseman Paper Ware 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215-003 unid be filed within Mental Hygiene. marked other ti	8	John Travers Lillie Frierson
nd h	욘	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 1915 North Longwood Street, Baltimore, Maryland
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic.	-	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Metro Crematory Inc. 07/10/2008 Baltimore, Maryland
Balt permit. Departi Import	ŧ	Sunature of Funeral Service Licensee 22. Name and Address of Facility The Derrick C. Jones F/H, P.A.
Physician		23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 21215 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart proximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease Death
``		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
od //	Exam	events resulting in death) Last Due to (or as a consequence of):
68760, er fifcate be executed uding physician and es as the burial - transit	Medical Examine	d. UNPENDED AMENDED
		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year
Box 6876 death errifical the atter ding ph	ician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
the dear	Physician/I	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. B rate death. Is after death. In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	۵	1 Yes 2 ✓ No 3 Probably 4 Unknown
ords v requires s been should	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Recc The lar	E	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital sician: s certif irector,	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Scene 5 Residence 6 Other: Scene
of Vi	의	27. Manner of Death 28a. Date of Injury (Month Day Year) (Month Day Year)
sion of trending Ph death. ctor: After i	jati Jatio	Natural 5 Pending 1 Yes 2 No
Divis pital or At ours after d ceral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
hou hou y fil		4
To To To Com	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Waryonte Due Youle O.C.M.E. July 5, 2008
5		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature
Registr	rar	141 0 8 2008 Mayer A- 1900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 16.32 PM JULY 05 2008 Fulwood Allen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GOOD SAMARITAN HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours 1 XM 2□ F 9-14-1930 S.C. Director 214-26-8095 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Italy Medical Experiment into the conflict at any Injury or other traumatic event, Italy Medical Experiment into the conflict at any once. 10d, Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director N/A MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21214 USA 2343 Montebello Terrace Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: 3 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BETHLEHEM STEEL College (1-4or 5+) Elementary/Secondary (0-12) N/A LABORER 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Archie Fulwood Rebecca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2343 Montebello Terrace Balto, MD 21214 Jimmy Fulwood- Son 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Pk: 7-11-2008 Randallstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East moral 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CANCER **Physician** METASTATIL GASTRIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760. by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a 1 Tyes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown PNEUMONIA DIABETES MELLITUS Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? URINARY INFECTION TRACT has 2 🗆 No 2 No 1 ☐ Yes 1 □ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 ☐ Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JULY 05, 2008 RES. 000 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ZUBAIL SHAIKH, GOOD SAMARITAN HOSP, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239 37 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 JUL 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H	lealth and N Death	lental Hygie Reg.		21819
N.	Physici Medic		Decedent's Name (First, Middle, Las	•	et Faulkr	ner		2. Date of Death Month	Day Year 29, 2008	3. Time of Death
1	Examir		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Death	
an Alle	Š. s. j			orth Kossuth Stre				more	N	
	Funeral Director		214-56-0129	7. Age (In	yrs. last birthday) 76	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan 6, 19	ar) Coui	place (State or Foreign ntry) Maryland
land	t ow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation			1.	Od. Inside City Limits
Mary	fied a	ţŏ	Maryland Baltim	ore City		В	altimore			1 XYes 2 No
th the	or 28g	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?
ath wi	23a ust b	ral	45 North Kossuth Street				21229		U.S.	۹.
36 s after de	ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Vas Decedent of H f Yes, specify Cuba 1 □ Yes 2□ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	etc.
15-0036	itural" al Ex	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:	16a Decer	lent's Usual Occup	ation	166	. Kind of Business/In	Black
215 ithin 72	n "na Medic	plet	(Specify only highest grad	de completed) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)					·
TZ diw b	giene er tha the	Completed	12	Conege (1-401 5+)		Hon	nemaker		Own F	lome
a pe	d d	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Maid	,	
Z Nould		P		Wilson					et Wilson	
Maryland nd 2 should be file			19a. Informant's Name/Relationship (7) Drewey Faulkner	/pe. Print)				^{ral Route Number, Ci} timore, Maryla i	ty or Town, State, Zip nd 2122 9	Code)
۾ په ج	of Health a Item 27 is other trai		20a. Method of Disposition	2	0b. Place of Dispos	sition (Name of			Location - City or To	own, State
mor Pages	nt: If		1 ☐ XBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			natory or other place us Memorial	i	07/05/08	Baltimore, I	Maryland
Saltimore, Jermit. Pages 1 a	Department of I Important: If its any Injury or of once.		21. Ignat re of Funeral Service Livens	7 -		. Name and Addres	ss of Facility		-	
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/ /	nysician Medical kaminer	_	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor	requence of):	bstrue ance	.1154111	or respiratory arrest,).	Approximate Interval Between Onset and Death
cate be executed	physician and s the burial-transit	al Examiner	Seque If ally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor			• "			
00/ tificate	g phys as the	edical		d						
The law requires that the death certifi	been signed by the attending should be detached for use as	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pr 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death 3 [Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
us, r	signed by	by Phys	Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	derlying cause give	en in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
ecords law requires	been	etec				·		1)		, –
	ate has page 2	Completed						24a. Was an autopsy performed 1 Yes 2	prior to co death? No 1 \(\sum Yes	psy findings available mpletion of cause of 2 No
VII.	recto	o Be	25. Was case referred to medical examiner?	Hospital:	0 E E E O	Othe	or.	h (Check only one)		
9 Phy	er this		27. Manner of Death	28a. Date of Injury	2 ER/Outpatient	, all box	4 Li Nursing Ho	me 5 Residence 28d. Describe how in	e 6 □Other (Specif	y)
r Attending	ath.	atio	1 Natural 5 □ Pending investigation	(Month, Day Yea	ar) Injury		<br Yes 2 ☐ No			
al or Atte	s after dea al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - building, etc. (Sp.	At home, farm, stre	eet, factory, office		28f. Location (Street City or Town, St	t and Number or Rura tate)	I Route Number,
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of my iner: On the basis of exal and manner stated.	knowledge, death mination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
Tot	To t	Ž	29b. Signatury and the offertified	MMUZ	Medical	29c. License	78160	29d.	Date signed (Month,	Day, Year)
-	13		30. Name and address of person who co	ompleted cause of death		Glehr	\$.	Beltima	mn7	1201
	Sta Registr		31. Date filed (<i>Month, Day, Year</i>) JUL 0 8 2008	32. Registrar's S	Signature	6)	1			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ For State	State of Maryl				d Mental Hy	giene		
		Registrar 1. Decedent's Name (First, Middle, Last	*)	Ce	rtificate of	Death		Reg. No.	2008	21820
Physic		Mary C. Fletcher	,				2. Date of De Month	Day 04	2008	3. Timelof Déath
/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De								10.00 р
		Genesis Eldercare			Baltimor			N/A		
Funeral Director		5. Social Security Number 6. Se 212–16~7893	x	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		/1924	9. Birthpi Coun Virg	ace (State or Foreign try) Inia
yland now at		10a. State 10b. County	10c.	City, Town or Lo	ocation				10	0d. Inside City Limits
ne Man Ba-f sl	ctor	MD00 N/A	Ba	ltimore						1 X Yes 2 □ No
th with the 23a or 2	Funeral Director	3302 Rueckert Ave	nue		10f. Zip Code 21214			10g. Citizer	of What Coun	try?
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	P S	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		Race - America Black, White, e	
5-0036 72 hours af hatural", or	eted	15. Decedent's Edu (Specify only highest grad	cation (e completed)	16a. Deced	dent's Usual Occup	ation	vorkina	16b. Kind	of Business/Ind	
2121 ed within giene. er than " the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired S Manager		roming	Reta	i l	
- 0 - 0 %	e	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,			
Maryland d 2 should be file th and Mental Hy 77 is marked oth traumatic event	은	Harvey L. Chase 19a. Informant's Name/Relationship (Ty	ine Print)	10h Mailir	ag Addross (Street	Alice	Cramer Rural Route Number	0" - T		2.11
Ma alth ar 27 is	1	Joyce Fletcher, D	•	I .			, Baltimo			Code)
Saltimore, Dermit. Pages 1 a Department of Hee mportant: If item any injury or othe		20a. Method of Disposition 1 Burial 2 MiCremation 3 F	20 Semoval from State		sition (Name of matory or other place		Date		ion - City or To	wn, State
t. Pag thment trant:		4 ☐ Donation 5 ☐ Other (Specify)	H		Svc. Corp		/07/2008			
baltimore, Marylar permit. Pages 1 and 2 should b Department of Health and Menta Important: If them 27 is marked any injury or other traumatic en ones.		21. Signature of Funeral Service Licens	Blan		Name and Address Name Address Name and Address Name Addre		Leonard , Baltimo	J. Ri re, M	uck, In D 21214	c.
		23a. Part1. Enter the disease, or complete shock, or heart failure. List only or	ications that caused the d ne cause on each line.	eath. Do not ente	er the mode of dyin	g, such as card	liac or respiratory ar	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		SLON					Onset and Death
Examiner		Sequentially list conditions	Due to (or as a cons	sequence or).						
l sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):						
execui n and ial-trar	Exan	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
ficate be executed a physician and is the burial-transit	dical		1							
X 00 Sertifica ding pt	/Med	IF FEMALE:	0. 16	_						
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 No 9 Unknown 9 Unknown							23d. Date of delivery Month Day Year	
ds, r	by	Part II. Other significant conditions cor		esulting in the un	nderlying cause give	en in Part I.	23e. Did to			e cause of death?
w requires to the second specific speci	lete	DIABETES MELL					24a. Was a			sy findings available
ificate has	Completed	25. Was case referred to medical	1103				- autop perfor 1□ Yes	rmed? 2 No	prior to corr death?	pletion of cause of
nysick nysick nis cert direct	o Be	examiner?	lospital: 1	☐ ER/Outpatient	t 3 DOA Othe		eath (Check only of Home 5 Resid		Other (Specify)
tending Phy eath. tor: After this	ition: T	27. Manufer of Death 1 V Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	/ at i? Yes 2 □ No	28d. Describe h			,
al or Atter s after dea al Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - Al building, etc. (Spe	home, farm, streetify)	eet, factory, office		28f. Location (S City or Tow	Street and No n, State)	umber or Rural	Route Number,
ne Hospit n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kner: On the basis of exam and manner stated.	nowledge, death ination and/or inv	occurred at the time vestigation, in my op	ne, date and pla pinion, death oc	ce, and due to the ocurred at the time,	cause(s) and date and pla	d manner as sta ice, and due to	ated. the cause(s)
To t To t	Σ	29b. Signature and title of certifier			29c. License		2		gned (Month, D	
2		Daylinsones.				6619			Y 5,	1005
9		30. Name and address of person who co	mpleted cause of death (MCES 6040	em 23a) (Type, F	ORD-	BALTHA	ORE, MI	0. 21	214	
Sta Registi	_	31. Date filed (Month, Day, Year) JUL 0 8 2008	32. Registrar's Sig	mature	,					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** FLORA G FLANAGAN JULY 2008 9:13P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year)
Sept. 22,1916

8. Birthplace (Country)
Alabama If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🔀 F 215-48-1484 91 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the McCleal Examinating the notified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21702 U.S.A. 7407 Willow Road Rm 258 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ⋧ White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi. th and Mental F 7 is marked otl Bob Griggs Edna May Kelly ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau Susan Snyder (Daughter) 17609 South 156 Street Springfield, Nebraska 68059 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 7-7-2008 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service License nc. Columbia, MD 21045 23a. Part . . . ter the disea . , o shock, or heart failur . List Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, complications that constitution the Immediate Cause (Final **Physician** ade disease or condition resulting in death) /Medical Due to (or as a consequen * of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month ģ in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 2 signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed; certificate 1 ☐ Yes 2 🗷 No 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/2 Yes 2 □ No 1 XÎnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Fell while coming out of bathroom 1 Natural 5 Pending investigation 4:55P 1 ☐ Yes 2 ☑ No death. 7/3/08 2 Accident Director: filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

City or Town, State)

Rd Apt 259

Frederick; MD 2/702 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after Homewood at Crum land Farms thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0

Box 68760,

P.O.

Records,

Division of Vital

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 100 GOODSON MARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Director 10-18-1930 SC 249-44-9984 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2702 FENWICK AVENUE USA 21218 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: 3 ▼Widowed 4 □ Divorced BLACK "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, If a Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BAKERY UTILITY WORKER Ith and Mental Hygie 27 Is marked other the traumatic event, In-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSH WITHERSPOON LINDY WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health (MARY PRITCHETT/DAUGHTER 449 E. LORRAINE AVE. BALTIMORE, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 40 1 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VET.CEM. 7-9-2008 CROWNSVILLE, MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stack, or heart failure. List only one cause on each line. Immediate Cause (Final months **Physician** rancreatic disease or condition resulting in death) Cance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 □Yes 1 □Yes ours after death.

Neral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar East University

32. Begistrar's Signature

Parting Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D101

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Year)

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:03 PM 2008 Isiah Gladney JULI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 N 2 F Director So. Carolina 98 Mar 30, 1910 213-07-5328 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 ☐ Xes 2 ☐ No Director **Baltimore** Maryland **Baltimore City** with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 U.S.A. 309 Denison Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🗌 No Baltimore, Maryland 21215-0036 1942 1 ☐ Yes 2 ☐ No Specify Specify: ģ Black 3 Widowed 4 Divorced 1945 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steel Worker Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Charity Gladney Dave Gladney ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1921 Winder Road Windsor Mills, Maryland 21244 Frank Gladney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Laurel, Maryland 07/09/08 4 Domation 5 ☐ Other (Specify) Maryland National Park Cemetery 22. Name and Address of Facility 21. Signatura of Funeral Service Licens Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final WEEKS **Physician** PNEUMON disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ANEMIA YEAR Sequentially list conditions, if any, leading to inimiconate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LYMPHOCYTIC YEARS CHRONIC signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month 5 ☐ Other (specify) □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLITUS 24a. Was an autopsy performed? certificate 2 **N**o 1 ☐ Yes 2 ☑ No 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No e Hospital or Attendi 24 hours after death. e Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AnushaR MID 22004 JULY 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUSHA IYER, SAINT AGINES HOSPITAL, 900 SCATON AVE, BALTIMORE, MD 21043

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 8 2008

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ORIGINAL

32. Registrar's Signature

burial-tran physician the burial attending p for use as t page 2 s

HOWLETT- WILLIAMS

MELCHA

Physician/Medical þ Completed Be Certification: To

after death.

Medical within 2

Hospital or Attending Physician: The law requires that the death

Division of Vital Records.

P.O.

yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an perform 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

Month

29d. Date signed (Month, Day, Year)

06/29/2008

BALTIMORE, MD 21239

Dav

24b. Were autopsy findings available prior to completion of cause of death?

4 Unknown

State

Registrar

KARHADKAR 31. Date filed (Month, Day, Year)

JUL 0 8 2008

29b. Signature and title of certifier

32: Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(M.O.)

5601, LOCH RAVEN BLVD ,

29c. License number

P20698

2008 21825 State of Maryland / Department of Health and Mental Hygiene James Aaron Holt 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last)
 James Aaron Holt Physician/ July 4, 2008 0705 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Sinai Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours 218-88-5480 Director Dec. 14, 1965 Yrs MD 1 XXM 2 F 42 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XX Yes 2 No MD Baltimore death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 603 Lanoitan Road 21220 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XXNever Married 2 Married 2XX No Ves è SpecAfrican American Yes 2 XX No specify: hours after 4 Divorced If Yes, Give Year ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) t: If item 27 is marked other than "natur other traumatic event, the Medisal Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene. bank 11 floor technician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Allen Holt De'Borah WEbb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
James Allen Holt / Father 3705 Lochearn Drive; Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State 07/11/2008 Catonsville, Maryland Western Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. Albert P. Wylie PR DVR 638 N. Gilmor Street; Baltimore, MD 21212
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 21217 Approximate Interval Physician Between Onset and failure. List only one cause on each line. Medical Death a. Atherosclerotic cardiovascular disease complicating Immediate Cause (Final disease , xaminer or condition resulting in death) Due to (or as a consequence of): cocaine use Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - trar Physician/Medical #23a,PII,2 Iter#21,perFH X AMENDED X UNPENDED 8/11/08 requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the Month Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown ed by the a 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 V Unknown Diverticulitis of sigmoid colon Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? . death? Yes 2 No 1 🗸 Yes 2 No certificate ... rrospital or Attending Physician: Th within 24 hours after death.

To the Funeral Director... 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other 1 Residence 6 Other: DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 V Yes 2 No ٩ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 4, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature

ORIGINAL

State Registrar

		For State	110000	State of	f Marylan		artment of F		l Mental Hy	giene Reg. No 20	NΑ	218	326
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/Medic		4a. Facility Name (If not	institution, g	1000	- 1	timore	4b. City, Town, o	r Location of De		Y-/	y of Death	<i>-</i>	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one)	-	and mann									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item / per fh 881 /-9-08 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6:55 DM era July 2008 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samari 50 TIMOVE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1**X** M 2 □ F 51 220 64 0330 Director MAY 14,1957 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at X ☐ Yes 2 ☐ No MD N/ABALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1253 HALSTEAD RD. 21234 USA · death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify BLACK 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Je filed with Elementary/Secondary (0-12) College (1-4or 5+) llTH h and Mental Hygie LABORER G.S.GIBSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi th and Mental I NED HARVEY ZELMA HALLOWAY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health an Important; if item 27 is any injury or other trau 1253 Halstead RD. BALTO, MD. ERICA Harvey (daughter) 21234 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) JULY 10,2008 BALTO, MD. KING MEM.PK. 21. Service Licensee 22. Name and Address of Facility CALVIN B. 1412 E. P 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition B. SCRUGGS FUNERAL HOME PRESTON ST. BALTO, MD. Approximate Interval Between Onset and Death strointestinal Hemorrhage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? Month Year 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify) P.0. detached 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate I 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this c 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To with 124 hours after death.

To the Funeral Director. 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month William Eugene Hayes, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimor Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) Months Days Hours 1₹ M 2□ F 1951 57 June 20, Maryland 220-48-0564 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 1 Tyes 2X No Owings Mills MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 10110 Shipes Lane 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11, Marital Status Black, White, etc. 1 ∑XYes 2 □ No If Yes, Give Year or Dates: 68-71 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify. Specify. 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Plumbing yrs Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Ellen Williams William E. Hayes, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Suzan Moore 10110 Shipes Lane Owings Mills, MD Fiancee 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem 7/8/08 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road 10 ien ELINE FUNERAL HOME Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Ye ar 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was ase referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 □ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

is been signed by the attending physician and should be detached for use as the burlal-transit has page 2 certificate After this certification, funeral director, p To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aff completely filled in by the fur

Physician

/Medical

Examiner

Director

Completed by Funeral

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Physician/Medical Examiner

Completed by

Medical Certification: To Be

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Funeral

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show

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Pages 1

Important: If item 2 any Injury or other once.

Physician

/Medical

Examiner

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Baltimore, Mary

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ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

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DHMH 17 Rev 1/2001

State Registrar



me and address of person who completed cause of death (Item 23a) (Type, Print)



Frankli

f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

are Dr. Baltimore MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day July 6, Hastings 2008 2:25A F. Thomas 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min. 1 X M 2 □ F 75 21, 1932 Aug. 212-30-6365 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2 🛛 No Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21136 10 Jill Court 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: ò 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TGMI Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Johnson William Hastings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Jill Court, Reisterstown, MD 21136 Wife Shirley K. Hastings 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 7/9/08 Finksburg, MD Evergreen Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home Com Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aspiration prevmenta weeks resulting in death) as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ∏Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2□ No 3□ Probably 4□ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop performed 2) 2 🗆 No Sensi 1 ☐ Yes 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation

death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit 68760. Box (P.O. I Division of Vital Records, this certificate has trail director, page 2 s Attending Physician: ours after death.

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ö Hospital 24 hours a

Physician

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Examiner

Director

Funeral

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within 72 hours after

12 should be fill the and Mental F. 7 is marked otl

Pages 1 and 2 ament of Health a tant: If item 27 is

injury or permit. Page Department o Important: If any injury or

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Completed by Be Certification: To

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towsontown MD

State Registrar 31. Date filed (Month, Day, Year) 2008 08

6 Could not be

determined

within 2

	Examin	er	4a. Fa
	Funeral Director		5. Soc 137 Usual
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the rollified at once.	To Be Completed by Funeral Director	Usual 10a. S Man 10e. S 3(11. Man 1
	Physician /Medical Examiner	ər	23a. I Imme disea result
09289	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	cause Cause that in resulti
, P.O. Box	that the death ce	y Physician/I	23b. V
Division of Vital Records, P.O. Box 68760,	The law requires cate has been sign page 2 should be	Completed by	
of Vita	y Physician; er this certific eral director,	n: To Be (25. W ex 1[27. Ma
Division	o the Hospital or Attending vithin 24 hours after death. o the Funeral Director: Afte completely filled in by the fune	Certification	27. Ma 1 [27. Ma 1 [2 [3 [4 [
	the Hosp hin 24 hou the Funer upletely fil	fedical	29a. 0
	0 = 0 5	-	29b. S

	State of Maryland /		ment of He				0 01000
	Registrar 1. Decedent's Name (First, Middle, Last)	Certii	ricate of D	eain	2. Date of Deat		3. Time of Death
ysician					Month	Day Y	ear
Medical caminer	Marie Antonetta Hagy 4a. Facility Name (If not institution, give street and number)	- 1	o. City, Town, or L	ocation of Death	July (01, 2008 4c. County of	
annie	307 Warren Road			sville		Baltin	nore
neral	5. Social Security Number 6. Sex 7. Age (In yrs. last b	"" I''' GUY /		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
ctor	137-16-3041 1□M 2XF 88	Yrs.	Days	Tiodio Willi.	Nov 3,	1919	Holland
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov	wn or Location	on				10d. Inside City Limits
lor for							1 ∐Yes 2 🙀 No
Director	Maryland Baltimore Cod 10e. Street and Number	ckeysv 1	10f. Zip Code		1	0g. Citizen of Wh	at Country?
al D	307 Warren Road		2103	0		USA	
iner must Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of His	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
y Fu	1 ☐ Never Married 2 🌠 Married 1 ☐ Yes 2 ሺ No		Yes 21 No	Specify:	, noun, one,	Specify:	vvinte, etc.
al Exam	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		21				White
t, the Medical E	(Specify only highest grade completed)	(Give kind	t's Usual Occupat d of work done du NOT use retired)	ring most of work		16b. Kind of Busi	ness/mastry
a luo	Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a		omemaker			Own Ho	ome
event, Be C	17. Father's Name (First, Middle, Last)		1	8. Mother's Name	e (First, Middle, I	Maiden Surname)	
To E	Cornelis Hallingse			Adrian	a Joha	ınna Var	oostendorp
any Injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type. Print) 19	b. Mailing A	ddress (Street ar	nd Number or Run	al Route Number	r, City or Town, St	ate, Zip Code)
tr tr	33.			ad, Cock			1030
or of	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	-	ory`or other place)		08	20c. Location - Ci	
, jury		_		. Garden	ıs	Timonium	n, Maryland
any lr once	Bryan W. Clary	Ler	ame and Address mmon Fun W. Pado	eral Hom	e of Dul	Laney Val	lley Inc. 21093
the burial-transit and label l	shock, or heart failure. List only one cause an each line Immediat (Cause (Fibridisease or conditions resulting in Jerun) Sequentially list conditions, if any heart of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	s of):	ASCU	AR	Disa	-AR EASE	Approximate Interval Between Onset and Death
Compressy med in by the following an incompleted by Physician/Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 9 □ Unknown		ctopic pregnancy ther (specify)			23d. Date Montl	
ed by P	Part II. Other significant conditions contributing to death but not resulting	in the under	rlying cause given	in Part I.			ute to the cause of death?
Completed					24a. Was a autops perford 1 🗆 Yes	sy pri- med? dea	ere autopsy findings available or to completion of cause of ath?]Yes 2 □ No
Be Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othor	26. Place of Deat			
15 La Cir.	1 Inpatient 2 EH/C	Outpatient 3	3 ☐ DOA ☐	4 🗀 Nursing no		ence 6 Other ow injury occurred	
tion	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	Work?	s 2 □No	200. 2000.150 1.	on injury occurred	
Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	farm, street,			28f. Location (S City or Town		or Rural Route Number,
edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge and manner stated.						
Me	29b. Signature and Title of certifier		29c. License	number 231	2 2	9d. Date signed (Month, Day, Year)
	· Clart 1 7		レンン	4)1.		July 2	, 2008
	30. Name and address of person who completed cause of death (Item 23a						m 01000
0	Charles Locke, M.D. 2360 W.			uite 306	, Luther	cville, h	MD 21093
State egistrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Carte	e .				

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cortificate of Death

			For State Registrar	State of Mary		epartment <i>Certificate</i>			ental Hy	giene _{Reg. No.} 2	008	21831
12			Decedent's Name (First, Middle, Last	st)					2. Date of De Month		Vear	3. Time of Death
	Physicia /Medic		Ka	nn Heste	~				7	_3_	SUPE	3 F M
5	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, 1	Fown, or Location				nne Arı	
			521 Rita Drive 5. Social Security Number 6. S	ex 7. Age (/	In yrs. last birth	nday) If Under		der 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign
	Funeral Director		217-58-2282	□M 2 X F	73 Y	rs. Months	Days Hou	rs Min.	April			ermany
	pu »		Usual Residence of Decedent 10a, State 10b, County	10	0c. City, Town	or Location		_				10d. Inside City Limits
	Maryla f shor	ō		ro Londo		Odento	n.					1X Yes 2 No
	r 28a- notifi	Director	Maryland Anne Aru 10e. Street and Number	mdei		10f. Zip				10g. Citize	n of What Cou	intry?
	th witl 23a o 1st be		521 Rita Drive				21113				ted Sta	
	tems tems	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Deced If Yes, spec	ent of Hispanic ify Cuban, Mex	: Origin? (Spe kican, Puerto	ecify Yes or No Rican, etc.))- 14	. Race - Ameri Black, White,	
36	irs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 □ Yes 2	2⊠ No <i>Sp</i> ed	cify:		S	pecify:	White
ž	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	ted	15. Decedent's En	ducation	16a.	Decedent's Usua (Give kind of wor life. DO NOT us	I Occupation	most of work	ing	16b. Kind	of Business/Ir	ndustry
7	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)						M-1	itary (Clothing
2	filed w Hygie Ither t	ပ္ပ	12 17. Father's Name (<i>First, Middle, Last</i>)		Sales A		•	e (First, Middle			CIOCHING
a	Ild be Tental rked c	To Be	Eberhard S	Scheller				Herta	Ursa	a1a	Schram	m
Maryland 21215-0036	2 shou and N Is ma		19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address	(Street and Nu					ip Code)
ره در	1 and lealth sm 27 ther tr		Joseph F. Hester	/husband		21 Rita Disposition (Namy, crematory or o			on, Mai Date		121113 Ition - City or T	Town, State
nor	ages ent of I t: If ite y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Hemoval from State 1		y, crematory or o erans Ce		7/8/	2008	Crown	sville	, Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign fure of Funeral Service Lice		MD VEC		d Address of Full		Home &	Crema	tory,	P.A.
n	9 8 E 8		Juanita X	homas		1411 A	\nnapol:	is Roa	d Odei	nton,	Maryla	nd 21113 Approximate
L			23a. Part Enter the disease, or con shock or heart failure. List only Immediate Cause (Final	plications that caused the one cause on each line.	e death. Do n			n as cardiac	or respiratory a	arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	consequence	Di:	25				-	2 years
N	Examiner		Commentally list conditions	h								
	78 (/ 1 8	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a o	consequence o	of):						
	ficate be executed physician and is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	consequence o	of):						
8760,	te be e ystciar ie buri	dical		d								
9	ertifica ing ph e as th	Med	IF FEMALE:									
Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1☐Live birth 2 4☐Pregnant at tir	Fetal death	3 □Ectopic po 5 □ Other (sp				23	d. Date of deli Month	ivery Day Year
o	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		020 (4						
О.	ss that gned b	by Pł	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying o	ause given in F	Part I.				the cause of death?
ord	w requires that s been signed to should be det	ted					_					obably 4 □Unknown
Sec	elawı hasbe je 2 sh	Completed							24a. Wa aut per	s an opsy formed?	24b. Were au prior to death?	itopsy findings available completion of cause of
a			25. Was case referred to medical				26.1	Place of Dea	1 Yes	2.2110-	1 □ Yes	22No
5	Physician: this certific	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 □ ER/Ou	tpatient 3 □ D0	Othor:		ome 5. Re		□Other (Spec	cify)
n o	ng Ph fter thi		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day			28c. Injury at Work?		28d. Describe	how injury	occurred	
sio	Attending r death. ector: After by the fune	catio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not I	ne 28a Place of injun	v - At home, fa	m street factor	1 ☐ Yes	2 □ No	28f. Location	(Street and	Number or Ru	ural Route Number,
Division or Vital Records,	after of Direct of in by	Certification:	4 ☐ Homicide determined	building, etc.		, 0004,	,,		City or T	own, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cerlific completely filled in by the funeral director,		(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e	examination an	e, death occurred d/or investigation	at the time, da	ate and place n, death occu	, and due to th	e cause(s) : e, date and	and manner as place, and due	s stated. e to the cause(s)
	To the P within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner state	ed.						signed (Mont	
	FRFÖ		1	MD -			100	10643	179	5	47/2	800
	20		30. Name and address of bersen who	o completed cause of dea	ath (Item 23a)	(Type, Print)	207 <	Sulto ?	00 An		MD 214	in l
	St	ate	31. Date filed (Month, Day, Year)	2. Registrar	's Signature	· skir gal	0 100 0	7107	201/1/1	Ast "	VI	
	Regist		uu 0 8 200	8 Marie	H A	rack						

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08-05090 Jeffr

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2008 21832

ey Lynn Hid		1 Eo	r State	state c	ot Maryia	na / De	Spartifica Certifica	ate of l	Death	una .		, 5		Reg. No.				
		Di-		idle,Last)								1 -	Date of D Month	Day	Year		Time of Death	
Physicia ⊮al Exami		1. 00	Social Control (Jeff	rey I	ynn I	lidde	n			J	July 2, 2	2008	. County o	f Death	14001110	
			acility Name (if not institu					4t	City, Town		cation of E	Death			Baltimore		ty	}
		Ť	7456 Old Battle Gro	ve Rd				dh el eu i	If Under 1		If Under 2	4Hrs.	B. Date of	Birth (MM	/DD/YYYY	g. Birth	olace (State or	
Funeral Director		5. S	ocial Security Number	6. Se	х М 2F	7. Age (In	yrs. last bir	Yrs.		Days	Hours				,1952	I Foreign	ntry) MD	
			17-58-8633 al Residence of Deceden		IVI Z												10d. Inside City	Limits
/ any			. State 10b. Cour	nty		10c	. City, Towr	or Location	on	Dur	ndalk						1 Yes 2	
and show	5		ryland	Bal	timore				10f. Zip Co		100				tizen of Wi			
Maryl r 28a-	Director	10e	Street and Number 7546 Old Ba	ttle	Grove	Road					21222	!		Un	ited	Stat	es	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show marie event, the Medical Examiner must be notified at once.	alD	11.	Marital Status		12. Was De	cedent Eve	er in U.S.	13. Wa	Decedent es, specify (of Hispa	anic Origir Mexican, I	n? (Spec	cify Yes o	r No-		e - Americ e, etc.	an Indian, Blac	sk,
eath w items ust be	Funeral	1	Never Married 2		Yes	2X	No								Specify:		White	Ì
e , 1		3			If Yes, Give Ye or Dates:		1-4\ 1460	Deceden	Yes 2 X	ccupatio	n (Give ki	nd of wo	ork done	16b	Kind of B			
jours a	l ba	1	5. Decedent's Education			(1-4 or 5+)	eted)	during m	ost of worki	ng life. [TON OC	se retire	ed)	1	C+ o	al Tr	dustry	71
36 n 72 h han "1 lical E	let et		Elementary/Secondary (0 12 Years	12)	Concgo	(1 1 0.0 7		Mil	wrigh									
withing giene	Completed	17	Father's Name (First, Mi	ddle, Lasi	i)					1:					en Surnam			
21215-0036 21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than	Be	:	Owen W. Hic	lden				emi teriin	- Addross	(Stroot	El:	izab beror Ri	eth i	Jane Number	Coyne City or To	wn, State	, Zip Code)	
21; lould be id Mer is mar	P	19	a. Informant's Name/Rela					19b. Mailin	g Address	(Silect	int	Tane	Ва	1 t i mo	re.	Mary.	land 21	219
MD and 2 sho alth and m 27 is		20	Mr. Jay W.	Hido	d <u>en</u> (Br	otner		e of Dispo	sition (Name	e of cerr	netery,		Date	20	C. LUCATIO	1 - Oity Oi	Toming Ottate	- 1
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important I filem 21 is marked other than "natural important if filem 21 is marked other than "natural important and other transmatic event, the Medical Examilia		1	⊠ Burial 2 Cren			from State	Hol!	natory or o Ly Hi	ther place)	m. G	dns.	7/5	/200	8	Midd	le R	iver, M	D
ti Pag	5	21	Donation 5 Oth	er Specif	y: ensee	0	<u> </u>	22.	Name and	Address	of Facility	/ ~ ~ 1	Home	of	Dunda	- 1k,	Inc.	
Bal Permi Depa		- 1	\sim	()			Sun	P	Name and A uda – Ri 922 W	uck lise	Ave.	Di	inda]	k, M	D 21 shock, or l	222_ neart	Approximat	e Interval
Physicia	n	23	3a. Fart I. Enjethe diser	se, or con	nplications tha each line.	t caused th	e death. Do	o not enter	the mode o	ar ayıng,	Suciras	a diac o	1000	.,			Between C Dea	
Medica amine		lr	mmediate Cause (Final di	sease	a. Hyperten Due to (or a	sive Ath	eroscler	otic Card	iovascul	iar Dis	sease							
.amm		1	r condition resulting in de		Due to (or a	s a conseq	derice or).											
		S 18	Sequentially list conditions any, leading to immedia	6	Due to (or a	s a consec	uence of):											
		= (cause. Enter Underlying (Disease or injury that initi events resulting in death)	ated	Due to (or a	s a consec	quence of):											
nd atted	- transit	֓֜֜֞֜֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֡֡֡֡	events resulting in death)		d												+	
£ 6	burial - tı	edical	UNPENDED	þ					/08 T	T					23d. Date	e of delive	ery	
760, cate be physic	the bu	آ /Me	F FEMALE: 3b. Was decedent pregna	nt in the		es, outcom ve birth	e of pregna	ancy 2	Fetal death	3	Ectop	ic pregn	ancy		Mont		Day	Year
Box 6876C e death certificate the attending phys	ise as	Physician/M	past 12 months?		4 P		time of deat		Other (Spe						Ì			
Box e death the atte	d for 1	ysi	1 Yes 2 No 9	Unkno	9 0	nknown	1 1 1 1	ulting in th	o underlyin	o cause	given in F	Part I.					to the cause of	
P.O. I es that the igned by t			Part II. Other significant	conditio	ns contributi	ng to death	but not res	sumng in m	e underlyin	g cadoo	9		1	Yes	2 No	3 🗸 P	robably 4	Unknown
S, P	d be deta	Completed by											24	a. Was ar		4b. Were	autopsy finding to completion o	gs available f cause of
ords w requ	plnous	틞											-	perform Yes 2	ned?	death	?	
Reco The law	page 2	Ĕ								26 Pla	ce of Dear	th (Chec						
tal Rec cian: The	ector,	Be	25. Was case referred to examiner?	medical	Hospital:	Inpatie	ent 2	ER/Outpat	ent 3	DOA	Other ₄		sing Home		Residence	6 🗸 O	ther: Scene	
Division of Vital Records, tall or Attending Physician: The law requirement and affect of the form of the certificate has been significant has been significant.	ral dir	2	1 Yes 2 27. Manner of Death	No	28a.	Date of Inju		28b. Time		28c. In	jury at Wo	ork?	28d. D	escribe h	ow injury o	ccurred		
n of Iding Pl	e fune	<u>ë</u>	1 Natural 5	Pendi	ng						Yes 2						D. J. Davida N	lumbar Cib
isio Atten	by th	Certification:	2 Accident	_	not be 28e.	Place of Ir	njury - At ho	me, farm,	street, facto	ry, office	e building,	etc.	28f. Lo	cation (S Town, St	treet and hate)	Number o	Rural Route	lumber, Gity
Div	lled in	erti	3 Suicide 6 Homicide	deterr	nined (So	ecify)							1	the serie	o(o) and m	anner as	stated.	- 1
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be writing 24 hours after death.	completely filled in by the funeral director, page 2	alc		fying Ph	ysician: To th	e best of m	ny knowledo	ge, death o	ccurred at t	he time, my opini	, date and ion, death	place, a occurre	ind due to d at the ti	me, date	and place,	and due f	to the cause(s)	
o the	omple	Medical			end mar	ner stated			12	29c. Lice	ense numb	рег			29d. Date	e signed	(Month, Day,Y	ear)
		Ź	29b. Signature and title	of certifier	//	M	١.			0.0	C.M.E.				July 3,	2008		
•			14hr	De	arkl	d cause of	death (Item	1 23a)										
C	b	y 16	30. Name and address Melissa Brasse		Assistan	t Medica	al Exami	ner 1	1 Penn	Street	, Baltim	ore, N	1D 2120	01				
		tate	D4 D-te filed (Menth C			Registr	ar's Signal	ire	coll									
		tate trar	11.11	118 1	COOR A	THE PARTY	-	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

		•	State Registrar		,	Certificate	of Death	,	Reg. No. 2008	21833
	Physicia /Medic		1. Decedent's Name (First, Middle, I Jane Clark Hinds	ast)				2. Date of Dea Month July		3. Time of Death
	Examin		4a. Facility Name (If not institution, g Heart Homes Luthe	,			n, or Location of Derville	Death	4c. County of Dea	th
	Funeral Director		218-26-2709	Sex 7. Age 1 ☐ M 2 X F	(In yrs. last birt			Hrs. 8. Date of Birt (Month, Da Septemb	9. Bir er 8,1927	thplace (State or Foreign ountry) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryla f sho	tor	Maryland Baltime	ore	Baltin					1 □ Yes 2 X No
	h the	Funeral Director	10e. Street and Number			10f. Zip Co	de		10g. Citizen of What Co	ountry?
	th with	ralD	6311 Boxwood Rd.			2121	.2		United St	ates
	er des items	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Deceden If Yes, specify	of Hispanic Origin Cuban, Mexican, P	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Whit	
36	irs aft	ğ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2XXIN If Yes, Give Year or Dates:	10	1 □Yes 2X	No Specify:		Specify:	vhite
2-0	72 hou nature	eted	15. Decedent's (Specify only highest of	Education	16a.	Decedent's Usual C	ccupation	f working	16b. Kind of Business	/Industry
121	vithin one.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of work of life. DO NOT use r homema		Working	own home	
2	filed v Hygie other i	ပ္	17. Father's Name (First, Middle, La	4 st)		Houseman		Name (First, Middle,		
<u>la</u> n	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the fledical Examiliar must be notified at	To Be	John Francis Cla	rk			Marie	Hibbits		
lary	2 shours and N is ma		19a. Informant's Name/Relationship						er, City or Town, State,	Zip Code).
<u>ک</u>	l and Health		Susan Jacobsen/d	aughter		L1 Boxwood		Baltimore,	MD 21212 20c. Location - City of	Town State
Baltimore, Maryland 21215-0036	Pages 1 ment of 1 ant: If ite ury or of		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			Disposition (Name y, crematory or other Valley Me	m GardJu	ly 8,2008	Timonium,	Maryland
Balt	permit. Pages 1 and 2 should by Department of Health and Menti Important: If item 27 is marked any Injury or other traumatic e once.		21. Signature of Funeral Service Lice	ensee N		Mitchel 6500 Yo	ddress of Facility -Wiedefe k Rd.	eld Funeral Baltimore	l Home, Inc , MD 21212	•
			23a. Mrt 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lir	the death. Do r					Approximate Interval Between
٧.	Physician		Immediate Cause (Final disease or condition		ILITY					Onset and Beath Mouths
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	of):				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consequence o	of):				
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39 ×	ertifica ding ph	Med	IF FEMALE:	00- 16	-4					
O. Bo	The law requires that the death certificate be execute ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transi	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal death	3 ☐ Ectopic preg 5 ☐ Other (spec			23d. Date of de Month	elivery Day Year
<u>s</u> , Р.	s that ined by detail		Part II. Other significant conditions	contributing to death be	ut not resulting in	the underlying caus	e given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	w requires been sign should be	ed b	Cancer, un	specifiz	<u>id</u>			1□'	Yes 2 □ No 3 □ F	Probably 4 Unknown
Record	The law re ate has be bage 2 sho	Completed by						24a. Was autop perfo 1 ∐ Yes	psy prior to primed? death?	autopsy findings available completion of cause of s 2 \(\subseteq \text{No} \)
Vital	Physlcian: The le r this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?					f Death (Check only o	/ >	
ot	Physic this or	ပ္	1 ☐ Yes 2 No 27. Manner of D ath	Hospital: 1 ☐ Inpatie		tpatient 3 DOA			dence 6 ☐ Other (Sp	ecify)
O	ling Afte fune	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Da	y, Year)	njury M	Injury at Work? 1 □ Yes 2 □ No		how injury occurred	
Division of	l or Attendi after death. Director: ≠ I in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine	to a	ury - At home, fa c. (Specify)	rm, street, factory, o			Street and Number or F wn, State)	Rural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C		Physician: To the best aminer: On the basis o and manner sta	f examination an					
	To the within To the comple	Me	29b. Signature and title of certifier	- 0		29c. L	cense number		29d. Date signed (Mor	nth, Day, Year)
	-		Dendall	Rhau	eller	ک ا	2564	6:	07/05/	2008
	10		30. Name and address of person where the second sec	no completed cause of d	eath (Item 23a)	(Type, Print) W. Towson	utown R	Blud/Ba	eto MD	21204
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 8	32 Jegistr	as Signature	Costo				

DHMH 17 Rev 1/2001

HINDS, Jane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21834 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LORETTA **JENKINS** В. Month **Physician** 3, A M July 2008 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death **Examiner** Maryley Neck Health & Rehabilitation Glen Burnie Anne Arundel 5. Social Security Number 408 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 215-30-8270 73 1935 Director Jan 28, Maryland Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Wadfoll Exacting to institute at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Glen Burnie 1 ☐ Yes 2 ☐ No Directo Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 USA 103 Furnlea Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>ک</u> Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Packer 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Vosholl Robert Jenkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 103 Furnlea Drive, Glon Burnie, Maryland 21060 Sharon White 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 7/7/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun al Serva Licensee Kevin E Ecker P.A. Name and Address of Facility McCully-Polyniak Funeral Hôme, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transli be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) the 9 Unknown as been signed by ' 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed page certificate ! 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 100 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ۲ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number 07-03-08 D57028

State Registrar Klakely

Amapolis MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

M.D.

1000

32. Restrar's Signature

ropra

JUL 08

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21835

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30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	_ 5. ₹ 5	[]	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed	(Month, Day, Year)
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9:55 PM **Physician** NSOV)u /Medical 4a. Facility Name (If no institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner .1 Chris OWSON 1Year If Under 24 Hrs. 1791 0 lowsor 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral 1 M 2 Z F Months Days Hours Min. r 407 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment in the retired at Mi Director Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?) RKS Funeral 12. Was Decedent Ever in U.S.-Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other trainment. College (1-4pr 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 001 ဥ H Usbani 1922Informant's Name/Relationship (Type Pript) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAY 1107 YORK 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1☐Burial 2☐Cremation 3☐Removal from State -10-08 Owna 4 ☐ Donation 5 ☐ Other (Specify) Sonature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ADENOCARLINOMA OF LUNG MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed of Vital 1 Tyes 2) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending P within 24 hours after death.

To the Funeral Director; After t completely filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier D64395 erson who completed cause of death (Item 23a) (Type, Print)

State Registrar OANIEUE 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

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DOBERMAN,

MO

32 egistrar's Signature

NEHARLES ST, SUITE 209 BALTIMORE, MO 21254

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 28, 12:45 P 2008 Irene Naomi Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie If Under 1 Year | If Under 24 Hrs. North Arundel Health & Rehab Center <u>Anne Arundel</u> 8. Date of Birth (Month, Day, Year) March 19, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 KMF Days Hours Min. 94 300-26-4998 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Clen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Hospital Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ XXNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ð Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important; if item 27 is marked other that any Injury or other traumatte. Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Rucker Clara Hutchinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Zoller 15 St Andrews Crossover, Severna Pk, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory July 1, 2008 Baltimore, ND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S, Glen Burnie, MD 21061 23a. Part1. Enter the disease, ir complications that caused the shock, ir heart failure. Let only on cause on each line r co-hplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and Due to (or as a consequence of): physician sthe burial Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Certification: 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier delival, MD 29d. Date signed (Month, Day, Year) DO029873 06/36/2008 BURNIE, Md. 21061 31. Date filed (Month, Day, State Registrar 2008

DHMH 17 Rev 1/2001

Box 68760.

P.O.

Division or Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** *20*08 /Medical Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner / Under 24 Hrs. 7. Age (In yrs. last birthday) If Unde 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) Hours Min. 1₽M 2□ F / Yrs. Months Davs Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examinat must be natified at once. 10h County ¥ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Place of Disposition (Name of Cemetery, crematory or other place) 20b. Date 20c. Location - City or Fown, State 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation 22. Name and Address of Facility 21. Signature of Funeral Service Lice Part I. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conseque To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tyes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 1 □ Yes ĴΝο 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 2 Medical Certification: To 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Naccident 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) www.ile 31 H-W AND KIMD 14812 0

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State

Registrar

31. Date filed (Month, Day,

Year)

08

gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** Day 200^{Year}_{8} Kemmerzell 4:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3713 Clayton Rd Harford Joppa | Months | Days | Hours | Min. | SEP 12 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 79 Mary land Director 218-28-8601 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show in than "natural", or items 23a or 28a-f show MD Harford Joppa 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3713 Clayton Road 21085 USA Funeral and 2 should be filed within 72 hours after death veath and Mental Hygiene. To 7 is marked other than "natural", or items 23: 12. Was Decedent Ever in U.S. Armed Forces? 1∑]Yes 2 □ No IfYes, Give Year or Dates: 1945–47 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Landscaper Greystone Golf Course 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Kemmerzell Margaret Brunn ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i <u>Peggy Kemmerzell/Wife</u> 3713 Clayton Rd Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 tment of F 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc | 7/5/08 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Prostate Cancer **Physician** Bony With Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) siclan and burial-transit requires that the death certificate be executed Exam Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown <u>a</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1euxemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? threat Cancer 24a. Was an page 2 s autopsy performe certificate Pancreatini 2 □ No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by within 24 hours after To the Funeral Direc 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31295

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10

State Registrar Wendy

31. Date filed (Month, Day, Year)

5701 Kenwood Ave

32. Registrar's Signature

Baltonos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KLOUSZ

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 200 g **Physician** 12:55AM Theodore Joseph Kees 114-7 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13 AUTIMORZE LOACHINGTON MEDICAL BURNIA Anne HRUNDE GIEN 8. Date of Birth (Month, Day, Jan 21, 7. Age (In yrs. last birthday) If Under 24 H Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Min. 1 ☑ M 2 □ F Months Days Hours 215-22-0307 80 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Modical Examiner must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Linthicum 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 530 Pritchard Drive 21090 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian med Forces Black, White, etc. 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White If Yes, Give Year or Dates Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F is marked ot Frederick Schmidt Kees, Sr. Isabelle Maye Baker ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Pages 1 and 2 530 Pritchard Drive, Linthicum, MD 21090 Mrs. Doris J. Kees/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Singleton Funeral & Cremation Svs. 1 2nd Avenue, S.W. Glen Burnie, MD 21061 Signature of Funeral Service Licenses M00918 Walten Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ATRIAL 1388 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi the attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown its certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 ☐ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an autopsy certificate ! 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 🗹 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manper of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deatle Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie my 20161. 31. Date filed (Month, Pay, . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			State of Mary	•	artment of h			giene leg. No. 2 () () 8	2181.1
			Registrar 1. Decedent's Name (First, Middle, Last)			Death	2. Date of Dea	th .	3. Time of Death
	Physicia /Medic		EVELYN B. K	COVE			07	04 2008	-1-
	Examin	er	4a. Facility Name (If not institution, give street and number) COOD SAMARITAN HOSPIT	ZL	2:	r Location of Deat	MA	4c. County of Death	/A
·	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hfs Hours Min.	8. Date of Birtl	n 9. Birtl	nplace (State or Foreign
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	yland at		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Lo	cation				10d. Inside City Limits
	e Marfish	Director	MD N/A	BALTIMO	RE				1 ŽiYes 2 □ No
	with the		10e. Street and Number 4000 N. CHARLES STREET, #40	10	10f. Zip Code	21218		10g. Citizen of What Co	untry? USA
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7	iled wi Hygien ther th		17. Father's Name (First, Middle, Last)		SOCIAL		me (First Middle	Maiden Surname)	HEALTH
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z v	1 and 2 Health a em 27 is other tra		RICHARD KOVENS / SON 20a. Method of Disposition 2	20b. Place of Dispo	sition (Name of		Date	TOWSON, MD	
allillo	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other pla LOH CONG		07/2008	BALTIMORE	, MD
00	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai		21. Signature of Juneral Service Licensee		2. Name and Addre			NSON & BROS	
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	Physician		shock, or heart failure. List only one cause on each line.		FUSION		,	,	Interval Between Onset and Death
	/Medical		resulting in death) Due to (or as a co		03107	40			
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	he dea the at thed fo	Physician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time 9 □ Unknown		Other (specify)			Month	Day Year
Ľ	s that t ned by e detac		Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ecolus,	equire sen sig ould b	ted b	COPS				1 🗆 \	/es 2 No 3 P	robably 4 Unknown
ב בי	e law r has be	Completed by					24a. Was	an 24b. Were at prior to death?	utopsy findings available completion of cause of
1131	in: Th lificate or, pag	e Col	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·	26 Place of De	1 □ Yes	2 No 1 ☐ Yes	s 2 No
>	nysicia nis cer direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA	hor:		dence 6 ☐ Other (Spe	ecify)
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INISIOII OI	Attenc r death sctor: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury-building, etc. (3	- At home, farm, str		Yes 2 □ No		Street and Number or R	ural Route Number,
5	ital or rs afte ral Dire led in t	Cert					City or To		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of more and manner stated	amination and/or in	th occurred at the nvestigation, in my	time, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
	To the	Me	29b. Signature and title of certifier		29c. Licer	ise number		29d. Date signed (Mon	th, Day, Year)
	1		1 mentina		90	051024		JULYC	4,2008
	12		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print) DCH RA	VEN BI	W BA	JULY C LTIMORE, N	(02/239
	Sta		31. Date filed (Month, Day, Year) 008 32. Registrar's	Signature (1)	le le				•
	Registr	ar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 2000 an 8:00 а м Jonell Lindholm 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 306 High Knob Lane Baltimore Reisterstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Min 1 □ M 2 TF Months Days Hours 372-68-5654 53 March 19,1955 Illinois Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ĀNo Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 306 High Knob Lane 21136 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 20 No 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Process Engineer Unilever Bestfoods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rev. William Lindholm Patricia Ann Schneider 19a. Informant's Name/Relationship (Type. Print) father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. William Lindholm 15343 Susanna Cir. Livonia, MI 48154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12,2008 Glen Eden Mem. Park Livonia, MI 22. Name and Address of Facility Eckhardt Funeral Chapel 21. Signature of Funeral Service Licenses 3296 Charmil Dr. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Cancinana 14 years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Cluse ase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner and

physician

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After 1

To the Hospital within 24 hours at To the Funeral L

filled in by the

Medical

P.O. Box 68760

Division or Vital Records,

Department of Health ar Important: If Item 27 is any injury or other trau

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or ite.

1 and 2 should be

Pages 1

3altimore, Maryland 21215-0036

Examiner burial-transi Physician/Medical the as for use þ signed b þ Completed Be Certification: To e Hospital or Attending P 24 hours after death. e Funeral Director: After t

IF FEMALE: 23b. Was decedent pregnant

Natural
Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manshell A. Levine 6569 Nonth C Charles Suite 205

and manner stated.

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

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State

Registrar

			State of Maryland / I	Department of Health a			
		•	1 _ State Registrar	Certificate of Death		Reg. No. 2008	3 21843
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) DELLA LEMON		2. Date of De Month	Day Year	3. Time of Death 7. 44 PM
No.	Examin		4a. Facility Name (If not institution, give street and number) GOD SAMARIZAN HOSPI7	4b. City, Town, or Location of A L 71	moRE	4c. County of De	ath
	uneral irector		5. Social Security Number 215−30−0007 6. Sex 1	Yrs. If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Bir (Month, Da 2-15-	th ay, <i>Year)</i> 9. B 1915	irthplace (State or Foreign Country) VA
and	wc		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits
Maryl	if she	tor	MD BALTI	MORE			XX Yes 2 □ No
th the	or 28a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	Country?
ath wil	23a	ral	1404 NORTHGATE RD.	21218		USA	
5-0036 72 hours after death with the Maryland	od other than "natural", or items 23a or 28a-f show event, the Macingal Examinar mast be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Oriels Yes, specify Cuban, Mexican 1 □Yes ② Specify:	gin? (Specify Yes or No i, Puerto Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, ite, etc. BLACK
21215-0036 ad within 72 hours aff	ical E	Completed	15. Decedent's Education 16a	Decedent's Usual Occupation	t of working	16b. Kind of Busines	
21219 within 7	an "r	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	or working		
led will	her th		12	DIETICIAN	wie Neme /First Middle		CON/BD.OF ED.
anc d be fi	red of	Be .	17. Father's Name (First, Middle, Last) LESLIE MORTON		er's Name <i>(First, Middle</i> FFIE STREET	, ivialgen Surname)	
Maryland od 2 should be file	Department of negating and mental important: if Item 27 is marked any injury or other traumatic evonce.	2		o. Mailing Address (Street and Number 1404 NORTHGATE RD	er or Rural Route Numb		, Zip Code) 218
stan	Item (20a. Method of Disposition 20b. Place o	of Disposition (Name of ery, crematory or other place)	Date	20c. Location - City of	or Town, State
altimore,	int: if		Lyburia: 2 Libremation 3 Linemoval nomi State	ORE NATIONAL	7-17-2008	BALTIMORE	, MARYLAND
alti.	Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility			
ന ഉ	2 = 2 9		James 9. Morton	1701-31 LAURENS		IMORE, MD	21217
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.		cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/sician ledical		Imme Me Cause (Final disease or condition resulting in death)		AILURE		
	aminer		Due to (or as a consequence	BRILL ATI	00		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):			
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8760, cate be exe	cian a	E	resulting in death) Last Due to (or as a consequence	of):			
87 icate	physics the b	dica	d				
Box 6	attending p for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of o	leliverv
death	e atte	icia	in the past 12 months? 1	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.O.	by the	hys	9 Unknown 9 Unknown		- T.,		
IS, res th	signed by the a	þ	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.			to the cause of death? Probably 4 Unknown
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tal ⊪: ⊥	certificate rector, pag	ပို	25. Was case referred to medical	26 Place	1 ☐ Yes	2 No 1 □ Ye	
f Vir	is cert direct	00	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/O	1011	rsing Home 5 Res		necify)
Division of Vital Records, alor Attending Physician: The law requires the after clearly	After this funeral di	Certification: To	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at Work?		how injury occurred	
isio Itendii	the fu	catic	2 Accident investigation	M 1 □Yes 2 □1	No		
Divi	Direct in by	rtifi	3 ☐ Suicide 6 ☐ Could flot be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
Division of Vital Records, P.O. Box 68760, & To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	Internet a long state of a factor and the completely filled in by the funeral director, page		29a. Certifier in Certifying Physician: To the best of my knowledg	e, death occurred at the time, date an	nd place, and due to the	cause(s) and manner	as stated.
To the Hospita	he Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination as and manner stated.	nd/or investigation, in my opinion, dea	th occurred at the time.	date and place, and d	ue to the cause(s)
To t	To t	Σ	29b. Signature and title of certifier Maw Sho Baul, M	29c. License number	G 1 2	29d. Date signed (Mo	
	_				913	JULY 5	2008
	6		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) 360/ Lo	CHRAVE	EN BOU	LEVARD
	Sta		31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Shellino	Kt, MA	MY LIND	0 21257
*	Registr		JUL 0 8 2008 Show It	Spection			
DHMH 1	17 Rev 1/20	001		ODIO!!!			
				ORIGINAL .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:15 AM 2008 Roy A. Link /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner t. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1⊠M 2□F 81 172-20-4474 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2K No Director <u>Maryland</u> Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 2019 Norhurst Way South Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 No lif Yes, Give Year or Dates: 1944-46 1 ☐ Never Married 2X Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. Specify: 3 Widowed 4 Divorced Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Railroad District Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Sperling Anthony Link ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2019 Norhurst Way South; Catonsville, MD 21228 Department of Health Important: If Item 27 any injury or other tra Dolores C. Link Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 7/11/2008 Garrison Forest 22. Name and Address of Facil Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses M01490 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): INFARCTION Examiner MYOCARDIAL 7 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-tran Division or Vital Records, P.O. Box 68760, 2 Due to (or as a consequence of): ttending physician or use as the buria use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by THYROIS HEAKT FAILURE CANCER 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No RESPIRATORY FAILURE WITH TRACH AND PEG 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar

31. Date filed (Month, Day, Year)

SAMUEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



P20661

2008

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			Registrar 1. Decedent's Name (First, Middle, Last)		Ce	rillicate of	Deam	2. Date of Death	No.Z U U 8	3. Time of Death
	Physici		Kenneth W.		Lyles			Month	Day Year 27, 2008	8:25A M
-	/Medio Examin		4a. Facility Name (If not institution, give street	and number)	11/100	4b. City, Town, o	r Location of Death	Julie 2	4c. County of Dea	
-1			Marley Neck Health &	Rehab		G1en	Burnie		Anne Arun	nde1
	Funeral		5. Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		218-20-1866 Usual Residence of Decedent		80 Yrs.			July 11,	1927	MD
	land ow		10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD Anne Arunde	L	Glen Burn	ie				1 □ Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	ountry?
	23a (23a (7575 Howard Road			21060		Ū	S.A.	
	tems er m	Funeral	11. Marital Status 12. W	as Decedent Eve med Forces? XYes 2 ☐ No	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
36	s afte	by F		XXYes 2 □ No Yes, Give ear or Dates:		1⊡Yes 2∭ZNo	Specify:		Specify: W	hite
9	filed within 72 hours after death with the Maryland Hygiene. uther than "hatural", or Items 23a or 28a-f show ant, the Madical Examination in cliffed at		15. Decedent's Education			dent's Usual Occup		16	b. Kind of Business	/Industry
Maryland 21215-0036	hin 7%	Completed	(Specify only highest grade con	pleted) ollege (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of workin d)	ng		
7	ygien /gien er tha	Con	0			Unknow	ı		Unknown	
nd	be file tal H d oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		iden Surname)	
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N N	d2st than 7 is r traur		19a. Informant's Name/Relationship (Type. P Mrs. Terry Sullivan/	-		•	and Number or Rura		-	
e,	1 and Heal tem 2		20a. Method of Disposition		20b. Place of Dispo				Baltiomre lc. Location - City or	MD 21202 Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	cemetery, createry createry createry.		July	8,	rownsvill	o MD
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			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can	s that caused the	e death. Do not ent	er the mode of dyir	ng, such as cardiac o	r respiratory arres	t,	Approximate Interval Between
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	is cer direct	10 B	examiner? 1 ☐ Yes 2 ☑ No	al: 1 🔲 Inpatient	2 ER/Outpatier	nt 3 DOA Oth			ce 6 ☐ Other (Spi	ecify)
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Division of	7 8 7 8	catio	2 Accident investigation			M 1 □	Yes 2 □No			
Ž	or Attending Physician: after death. Director: After this certifici in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of Injury building, etc. (At home, farm, str Specify) 	eet, factory, office	2	28f. Location (Stre City or Town,		Rural Route Number,
	pital ours a eral C filled	8	29a. Certifier 1 NCertifying Physician	· To the best of r	my knowledge deat	n occurred at the ti	mo, data and place	and due to the cou	sea(e) and manner	as stated
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the	edical	(Check only 2 Medical Examiner: 0	on the basis of ex and manner stated	camination and/or in	vestigation, in my	opinion, death occurre	ed at the time, dat	e and place, and du	e to the cause(s)
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			Malelon	BW_		D-1	40251	3	me 27,	2008
	1		30. Name and address of person who completed	ed cause of deat	th (Item 23a) (Type,	Print) 325	HOSPITAL	DRIV	E Sugt	E 208
			DROCHANES	-		gret	HOSPITAL & BURNIG	E, MD	20061	
	Sta Registra		31. Date filed (Month, Day, Year)	. Registrar's	Signature	1.				
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		,	State of M 1 - State Amend #25&27, perME, g	aryland / [881 7/8/	Department of F	Health and N <i>Death</i>		giene Reg. No. 200	8 21846
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	/Medic	al	JEROME 4a. Facility Name (If not institution, give street and number	•)	LENET	r Location of Death	07	4c. County of De	
	Examin	er	Sinai Hospital of Balti			imore C	city		N/A
	Funeral Director		5. Social Security Number 6. Sex 7. A 1 M 2 F	ge (In yrs. last bii	rthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Da 05/01/	1920 9. Bi	rthplace (State or Foreign Country)
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	Maryla -f sho	ţō	MD BALTIMORE		SVILLE				1 □ Yes 2 🛣 No
	or 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	
	ath wi		1 GRISTMILL COURT, APT.			21208		USA	
036	be filed within 72 hours after death with the Maryland Hygiene. I hygiene. I other than "natural", or items 23a or 28a-f show event, if a five leaf Examir or must be rediffed a event, if a five leaf Examir or must be rediffed a	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛣 No		ecity Yes or No- Rican, etc.)		
2-003	"natural",	eted	15. Decedent's Education (Specify only highest grade completed)	16a	. Decedent's Usual Occur (Give kind of work done	during most of work	ing	16b. Kind of Busines	s/Industry
121	l within 72 ho jiene. r than "natu ii o We jiesi	Completed	Elementary/Secondary (0-12) College (1-4or 5+	5+)	life. DO NOT use retire PODIATRI	,		PODIA	TRY
מ	be filed ttal Hyg d other event,	BeC	17. Father's Name (First, Middle, Last)				•	Maiden Surname)	NIC & TC KV
Maryland	d 2 should the and Menit is marked traumatic e	ို	HERMAN		LENET D. Mailing Address (Street	JULI			UGATSKY
			19a. Informant's Name/Relationship (Type. Print) ELAINE LENET / WIFE		GRISTMILL C				
altimore,	ーエる幸		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place o	of Disposition (Name of ery, crematory or other place	i	Date	20c. Location - City of	r Town, State
Ĕ	Z if e		4 □ Doration 5 □ Other (Specify)	BALT	IMORE HEBREN		72008	REISTERST NSON & BRO	
g Ra	permit. 1 Departm Importar any Inju		21. Signature of Funeral Service License	2	22. Name and Addres				E, MD 21208
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause of each	ed the death. Do					Approximate Interval Between
J.	Physician		Company (Final)	2i2					Onset and Death 24 hours
	/Medical Examiner		Due to (dra	s a consequence	of): actiufec	Lou	-	0.	48 hours
	it d	ner	Sequentially list conditions, if any leading to minimal accause. Enter Underlying Cause, (Disease or injury	s a consequence	of):	110-1	· Das	Edward	
	e executed ian and urial-transit	Examiner	that initiated events c.	s a consequence	of):		BY MEDICA		
760,	te be e; ysician e buria		d	·	·		PPROVED B		
89	ertifica ing ph	Medi	IF FEMALE:			Cy CERTE MON			
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	2 Fetal death at time of death	h 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy celul		23d. Date of d Month	lelivery Day Year
ω, σ.	w requires that the dispersion is been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death	but not resulting i	in the underlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
org	require een sig nould b	ted	chronic renal faile				1 🗆 '		Probably 4 Unknown
Records,	has b	Completed	hypertension, Polycy	^	rubra v	era	24a. Was autop perfo	an 24b. Were prior to death	autopsy findings available o completion of cause of ?
		a	Left trochayteric 25. Was se referred to medical	· trac	-ture	26. Place of Dea	1 □Yes	2 Mo 1 □Yo	es 2 LINO
ot <	hysici his cer I direc	To B			utpatient 3 100A	ner: 4 Nursing H		dence 6 ☐ Other (S)	pecify)
o C	Attending Physician: or death. ector: After this certific by the funeral director,	ion:	27. Manner of Death 28a. Date of In (Month, D		Time of Injury 28c. Inju	ry at rk?]Yes 2 No	28d. Describe	how injury occurred	
Division	Atten	Certification:			arm, street, factory, office	7.10	28f. Location (City or To	Street and Number or	Rural Route Number,
	ital or Irs afte ral Dir led in			PI	which		1 Gristin	ill Court,	Apt. #201
	Hosp 24 hou Fune etely fil	ledical	29a. Certifier 1	of examination a					
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Mec	29b. Signature and title of certifie		29c. Licens			29d. Date signed (Mo	
	T) AND M	0	RE	S-000	> !	07/04/	2008
/	2		30. Name and address of person who completed cause of Jan Fritz HD S	death (Item 23a)	(Type, Print)	of Ra	Himo	re	
1	Sta	ite		trar's Signature	had a	1 40			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** 2 2 12 8 8:35 P M EDWIN C. MARTIN /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Joseph Medical Center Saint Towson If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1**X**□ M 2□ F 5/27/1920 Director 710-09-5909 88 MARYLAND Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County d other than "natural", or items 23a or 28a-f shovevent, the Medical Evaminer must be notified at 1 ☐ Yes 2X No Director TOWSON BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 death 300 BROOK ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. TYPES 2 No If Yes, Give Year or Dates: WWII filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHTTF. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ath and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT SECRETARY OF MIRRAY B & O RAILROAD

18. Mother's Name (First, Middle, Maiden Surname) 12TH GRADE 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nant of Health and Mental GEORGE MARTIN BESSIE ပ COURTNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Departmant of Health an Important: If item 27 is any Injury or other trau once. TOWSON, 300 BROOK ROAD MD21286 GLORIA MARTIN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DRUID RIDGE CEMETERY 7/10/2008 PIKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Speqify) e of Funera Service Li ensee 22. Name and Address of FacilityTHE JOHNSON FUNERAL HOME, P.A. leath 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION RIGHT LOWER LOBE PNEUMONIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). sician and burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, δ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 Å No After this certificate I funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ANatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death. death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 9 To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of pertilier 29c. License number 29d. Date signed (Month, Day, Year) D 58944 06, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 TOWSON, MARYLAND 21204 OSLER DRIVE. CHRISTINE BOUTTALE M. D. .. 31. Date filed (Month, Day, Year) JUL 0 8 2008 32. Registrar's Speature State Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #5, perFH g882 8/13/08 TT

Certificate of Death

Reg. No. 2 0 0 8 Reg. No. 2 0 0 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:15 A M D) RI 07-03-0 8 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balto SON ando 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yṛs. last birthday) 6. Sex **Funeral** Days Months Hours Min 1□M 2**Z**F Director 10-16-19 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 res 2 No IIMUre Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ton Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: Specify: 3 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omesti suse l of Health and Mental Hygic If item 27 Is marked other or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Informant's Name/Relationship (Type. Print) Raughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Village 20b. Place of Disposition (Name of cemetery, crematory or/other place) Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, cire. 1 Burial 2 □ Cremation 3 □ Removal from State emeter 107-09-08 permit. Page Department of Important: If any Injury or UNIDAL 4 ☐ Donation 5 ☐ Other (Specify) 21: Signature of Funeral Service Licensee 22. Name and Address of Facility BERTY 14 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a flac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) embolism **Physician** ulmonary /Medical Due to (or as a consequence of): Examiner ertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Percholesterolemia the burial-transit and death certificate be exec Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an autopsy performed? page 2 certificate 1∐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asadi . #209 Timonium, MD Cyrus OE. Timonium rel Registrar's Signature 31. Date filed (Month, Day, Year) State 08 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JOHN CARROLL MONAGHAN JUNE 30, 2008 8:37 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST CENTER TOWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral 1X**□ M 2 □ F Months Days Hours Min. 86 215-16-0655 Director 10/30/1921 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo TOWSON MD BALTIMORE death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a USA 1709 CIRCLE ROAD 21204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \ X*es 2 \ No If Yes, Give Year or Dates\WXII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Englishment Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐XNo Specify ģ Specify: 3 Wildowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RAILROAD SALES MANAGER 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD MONAGHAN NELLIE UNAVAILABLE မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET E. MCHUGH/DAUGHTER 1709 CIRCLE ROAD TOWSON, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial, 2 ☐ Cremation 3 Removal from State GARRISÓN FOREST 4 □ Donation 5 □ Other (Spegify) 7/7/2008 OWINGS MILLS, MD CEMETERY e of Fun ral Lervic - Leensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical c (sequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, nding physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 D Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) Ö the a ☐Yes 2 ☐ No 9 Unknown ed by t detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by been signe should be c 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy perform this certificate 2 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ∏ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To After thi funeral Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Accident 5 Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 🗆 Yes 2 🗆 No 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier **Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 6 Date filed (Month, Day, 8 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 06 2008a Physician 19:48 P M Edward Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Bon Secours Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Month, Day, Feb. 23, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1⊠M 2□ F 67 214-40-0136 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "horical Evantity or at the notified at once. 10c. City, Town or Location 10a. State 10b. County 1-XYes 2□No Director **Baltimore** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21223 1217 West Fayette Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11, Marital Status Never Married 2☐ Married 1 ☐ Yes 2 XNo Specify: Specify: Black altimore, Maryland 21215-0036 If Yes, Give Year or Dates: ゑ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) construction company construction worker 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 520 Red Oak Drive; Severna Park, Maryland 21146 Natella Gray / Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 07/02/2008 Catonsville, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Find Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 🗹 No certificate 1 ☐ Yes this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death. he Funeral Director: A bletely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide completely filled

State Registrar

Medical

DARSHAN. S. 31. Date filed (Month, Day, Year) 8 2008 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of certified

. Registrar's Signature

within 2 To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Royal Ave, Rallinge MD 2/2/7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend items / 10f per fh g881 /-8-08 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Masincupp 1630M 2008 Illam 0 oa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Applans Bayview Hospital Bactimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1**X**M 2□ F 50 49 218-74-088 01, 17,1958 Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 TXYes 2 TNo Director MD Baltimore Dundalk with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 2900 Dunleer Road Funeral USA 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify Specify:White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other than traumatic event, the M Retail Sales Self-Employed 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William E. Masincupp, Sr. Rita C. Schaub ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a William E. Masincupp, Sr. 3408 Loganview Dr., Dundalk, MD 21222 item 27 r other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7-8-08 Baltimore, MD 22. Name and Address of Facility 21. Signature of Euro Bradley-Ashton Funeral Home, PA, 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days neumania disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner irrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Chron's Discase physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified 00064935 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview

Registrar

State

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2008

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31. Date filed (Month, Day, Year)

MD

JENNIFER SANTON PAC

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	Hern de	'n.	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No).S.GIIIC (S.	If Yes, spe	cify Cuba	n, Mexican	, Puerto P	lican, etc.)	Bla	ck, White	, etc.	
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State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day JUL Y **Physician** 2008 4:20A MOYE CHARI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SEASON'S HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day 1949 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Gountry) MD **Funeral** Months Days Hours 1 □ M 2 1 F 59 220-56-3744 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminar must be notified at 1 □Yes 2X No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21244 USA 3712 OLD MILLFORD MILL ROAD Funeral 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Its Ma Elementary/Secondary (0-12) College (1-4or 5+) REFLEXOLOGY REFLEXOLOGIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ZESKIND KOMITZSKY BERNICE BENJAMIN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21244 3712 OLD MILLFORD MILL ROAD, BALTIMORE, MD LAWRENCE MOYE / HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 07/07/2008 OWINGS MILLS, MD HAR SINAI CONG. 4 □ Donation 5 □ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Sign fure of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Breast disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 nknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 1 ☐ Yes 2 ☐ No 1 Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 ther (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier taymord Miller MD 08 D47683 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) Miller Kershytown Kuymord Sirect Surte 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 08 Registrar

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2	.) le		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dorothy Serry, MD 25 Main Street Suite 200 Reisterstown, Mch 21136								1136	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day **Physician** Sandra Lee Neary 2008 6 5:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months July 30,1950 Maryland Director 217-56-5036 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD 1 ☐ Yes 2 No Director Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, I'm Invidical Examiner must be I 21212 USA 10 Murdock Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 X No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Appel Rudolph Gogolla 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traunonce. Nicole Weakland/ Daughter 10 Murdock Road Baltimore, MD 21212 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Evans Funeral 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 07/07/08 Forest Hill, MD Chapel-4 ☐ Donation 5 ☐ Other (Specify) Bel Air 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death S Mouths IVER Immediate Cause (Final NOSTAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) g ☐ Unk*n*own g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 6 Nother (Specify) HOSPIC Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

be executed attending physician and for use as the burial-tran P.O. Box 68760, signed by the a d be detached for Records, s been s certificate has page 2 Division of Vital Physician: funeral director, After this death. al or Attendi s after death. Il Director: A the f filled in by within 24 hours a

To the Funeral C

completely filled

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72 hours after

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than ".

3altimore, Maryland 21215-0036

Certification: To

6 Could not be determined.

4 Homicide

Wendall +

29a. Certifie

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltomo 21204 555 W. Towsentown Blud, MD. 32. Restrar's Signature

State Registrar

Medical

31. Date filed (Month, Day, Year) 2008

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ORIGINAL

death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending death. Funeral Director: stely filled in by the hours after completely 24 the ro the

Maryland 21215-0036

Baltimore,

2

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day,

29b. Signature and title of certification

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3508 Bank St.

32. Registrar's Signature

and manner stated.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2°2′1218 21:45FM William Edward Patterson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death **Examiner** Towson Baltimore Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days **X**□ M 2□ F 91 338-14-1307 Illinois Director 21 1917 April Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 28a-f show "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 ☐ No Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 21030 USA 32 Cedar Knoll Road permit. Pages 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23 any injury or other traumatic event, the Medical Examiner must once. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Specify: \$ 46 white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grounds Maintenance Maintenance n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive May Middleton Walter Patterson ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Cedar Knoll Rd., Cockeysville, MD 21030 Ruth L. Patterson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【*** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (**Specify) Metro Crematory 6/13/08 Catonsville 21. Signature of trace Service Licknese 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. Michael J. Flagle 10 W. Padonia Rd., Timonium, Approximate Interval Between Onset and Death 23a Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE PULMONARY FIBROSIS **Physician** /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any localing L. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown PNEUMONTA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s ALZEIMER'S DISEASE autopsy performed? 1 ☐ Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No within 24 hours after death,

To the Funeral Director: After this c
completely filled in by the funeral dire Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 6-12-08 D37254

(ex)

State Registrar

DHMH 17 Rev 1/2001

DRIVE TOWSON.

MARYLAND 21204

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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30 Registrar's Signature

			. For	State of Ma	ryland /			Health and M	lental Hy	giene	0000	0.1	0.50	
			State Registrar			Cert	tificate of	Death		Reg. No. (2008	21	820	
	Dhaniai		1. Decedent's Name (First, Middle, Las	st)					Date of De Month	ath Day	Year	3. Time o		
	Physicia /Medic		Edith Mae Pa		July	6	2008	8:4	5 P M					
	Examin	er	4a. Facility Name (If not institution, give	n, give street and number) 4b. City, Town, or Location of Dea						4c. County of Death				
Ja de			Manor Care of Si	Silver Spring Silver Spring Montgo							Montgon	ery	or Foreign	
	Funeral		1	5. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)						Cour	Birthplace (State or Foreign Country)			
	Director		410-20-4087 Usual Residence of Decedent		87	115.			Feb. 20	19:	21 Arka	nsas		
	and bw		10a. State 10b. County		10c. City, To	wn or Loca	ation				1	0d. Inside (City Limits	
	Mary f sh	Ď	MD Montgom	erv	c	ilwo.	r Spring					1X Ye	s 2∏No	
	the 1	Director	10e. Street and Number	CLY		TIVE	10f. Zip Code			10g. Citiz	en of What Cour	itry?		
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Evanisher must be notified at		8505 Springvale	Road. Ant	#227	,	209	1.0			USA			
	ns 2	Funeral	11. Marital Status	12. Was Decedent E				Hispanic Origin? (Spo ean, Mexican, Puerto	ecify Yes or No)- 1	4. Race - Americ			
٥	ifter (1 ☐ Never Married 2 ☐ Married	Armed Forces? 1	0		_		mican, etc.)		Black, White,			
5-0036	al", c	b	3 X Widowed 4 ☐ Divorced	□Yes 2 X No	<i>Зресну</i> .			Specify: Wh	ite					
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⊆	be fil ntal H M otl	Be	17. Father's Name (First, Middle, Last)								ourname)			
5	should and Mer s marke umatic	욘	Will Osco Low	•					Mae Hic		T C4-4- 7:-	Code		
	N - 10		19a. Informant's Name/Relationship (,	t and Number or Run						
ď	s 1 and 3 f Health item 27 other tr		Linda Jo Ann Gold 20a. Method of Disposition	berg/Daugh				ircle, Su	ite 350 Date		<u>Laurel</u> , cation - City or To		20724	
Ö	ges nt of l		1 ☐ Burial 2 ☐ Cremation 3 【☐ Removal from State									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
altimore	it. Pa rtmer rtant rjury													
g R	permit. Pages 1 Department of I Important: If ite any injury or ot once.		21. Signature of Euneral Service Licer	Show I	M0110			D(.A.	
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	Obveriales		shock, or Meart failure. List only one cause on each line.										d Death	
4	hysician /Medical		disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of):											
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Electrolyte Imbalance Due to (or as a consequence of):										
	ansit	Examiner	Cause (Disease or injury that initiated events	Cerel	orovas	cular	accide	nt				Wee	ks	
o Î	ficate be executed physician and street transit is the burial-transit	Exa	resulting in death) Last	Due to (or as a										
2/60	ate be sysici	lical		d										
S	death certificate e attending phys d for use as the l		IF FEMALE:	•										
X RO R	th ce tendi r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth			Ectopic pregnan	су		2	3d. Date of deliv Month	ery Day	Year	
	e dea he at	sici	in the past 12 months? 1 □ Yes 2 □No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	h 5□	Other (specify)				Mortar	<i>D</i> ,		
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=======================================	sician: The law s certificate has b lirector, page 2 sl	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Deat	h (Check only	one)				
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<u> </u>	ttend death stor: / the	icat	2 Accident investigatio 3 Suicide 6 Could not b	e 28e Place of Inju	ry - At home	farm stre		1103 2	28f Location	(Street and	d Number or Rui	al Route N	lumber,	
DIVISION	lor A after Direc 1 in b)	Certification: To	4 Homicide determined	building, etc	(Specify)	,, 0110	, iadidiy, dilide		City or To	wn, State)			
_	To the Hospital or Attending Physician: In thin 24 hours after death as the Funeral Director: After this certifica completely filled in by the funeral director; to		29a. Certifier 1 Certifying Pl	nysiclan: To the best of	f my knowle	dge, death	occurred at the	time, date and place	, and due to th	e cause(s)	and manner as	stated.	:e(s)	
	ne Ho n 24 l	Medical	(Check only 2 Medical Examone)	nIner: On the basis of and manner sta	examination ted.	and/or inv	estigation, in my	opinion, death occur	rred at the time	, date and	place, and due	o the caus		
	To the To the To the To the To the To the Comp.	Me	29b. Signature and title of certifler	0-0	^		1	ise number			e signed (Month	Day, Year	r)	
	,		Kamah	K. (1	rli'		De	1609		7.	7.08			

State Registrar R. Tuli

31. Date filed (Month, Day, Year)

JUL 0 8 2008

DHMH 17 Rev 1/2001

ORIGINAL

10810 Darnstown Road, Suite 202, Gaithersburg, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** 2048 Gertrude Powell July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Hospital 13 a Himore Daint Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Months Days Hours Min Director 212-20-9435 83 Jan 14, 1925 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Examinar must be notified at Director 1 XYes 2 No **Baltimore** Maryland **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 Allendale Street 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: Specify: Specify: β 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maryland Cup Company **Machine Operator** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Queenie Green Norman Green ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traum once. 20 Jameson Lane Pikesville, Md. 21208 Queenie E. Hudson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/07/08 Baltimore, Md. **Baltimore National Cemetery** 22. Name and Address of Facility 21. Signe ure of Funeral Service Estep Brothers Funeral Service, P. A 1200 Future Place Rattimere, Md 21.
23a. Part 1 Enter the disease, or complications that caused the divath. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme one Cause (Final disease or condition resulting in death) **Physician** Gastrointestinal bleed /Medical Due to (or as a consequence of): Examiner Mrosegsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Run-1 Acute Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Be Completed by Certification: To

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Powell, Gertrude Hospital or Attending Physician:

72 hours after

filed within

should be

altimore, Maryland 21215-0036

sician and burial-tran physician s the burial attending p for use as t signed by the a d be detached for ficate has been siç r, page 2 should b After this certificate funeral director, page iours after death.
neral Director: A
filled in by the fu

							1 ☐ Yes 2 ☐] No 3□ Probably 4X Unknown			
							24a. Was an autopsy performed? 1 ∐Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No			
25. Was case referred to m	edical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 X No	[Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
	Pending nvestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	286	d. Describe how injury occurred				
	Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					of. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1X Ce (Check only one) 2 ☐ Me	rtifying Phy dical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death oc tion and/or invest	curred at	the time, date and place on my opinion, death occ	e, an	nd due to the cause(s) I at the time, date and	and manner as stated. place, and due to the cause(s)			

State Registrar

Medical

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

AS24385284106

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Ave

21229 Baltimore, MD

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ng 32. Registrar's Stynature

within 24 hours a To the Funeral D

completely

State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 **Physician** 13²4 2008 Mary Margaret Panuska 11:30 p^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Oak Crest Care Center if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** Days (Month Day Year) 05/23/1916 Hours Min 1 ☐ M 2 🔀 F Maryland 92 213-01-7289 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No by Funeral Director Baltimore Baltimore MD permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-yn Julury or other traumatic event, the Medical Examiner must be notified and. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 U.S.A. Apt. 3415 8820 Walther Blvd. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2∭XNo Specify. White 3 Widowed 4 □ Divorced Maryland 21215-00 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturer Office Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah A. Cox Michael J. Browne ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 9523 Perry Hall Blvd. Perry Hall, MD 21236 Catherine Harrison, Niece timore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/09/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Bai (Natandra 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burialphysician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier H0052365 16 Waltha-Belovard, Perhalle Maryland 21234 cause of death (Item 23a) (Type, Print) 8800 00. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 8 Registrar

PARWSKA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY POLIN 2008 8:27 Ам ROSA 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A SINAI HOSPITAL OF BALTIMORE BALTIMORE 9. Birthplace (State or Foreign Country) GERMANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 1 F Days Months Hours Min. 1070371913 94 212-28-9860 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 X Yes 2 □ No BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USÁ 21209 3041 FALLSTAFF ROAD, #603D 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 □ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER JEWELRY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SCHWARTZBAUM EVA KAMINSKI MANUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RACHEL FINIFTER / DAUGHTER 2000 ISLAND BLVD. #2205, AVENTURA, FL 33160 20b. Place of Disposition (Name of cemetery, crematory or other r 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HÉBREW CONG. 07/06/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0455 disease or condition resulting in death) Due to (or as a consequence of): Due to or as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown

Physician /Medical Examiner

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attending physician for use as the burial

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After

death.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending

that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician

Examiner

Funeral

Director

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination at the notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, It. M.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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Physician/Medical

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Certification:

Medical

MD

Sequentially list conditions, if any sequentially cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

n in Part I.	23e. Did tobacco us	se contribute to t	ne cause or death?
uns	1 □ Yes 2 %	No 3□ Prol	oably 4 ☐ Unknown
	24a. Was an autopsy performed?	24b. Were auto prior to co death? 1 □ Yes	opsy findings available oppletion of cause of
26. Place of Death	(Check only one)		

25	. was case referred to medical
ĺ.	examiner?
	1 ☐ Yes 2 ☑ No
27	Mannay of Dooth

Hospital: 28a. Date of Injury (Month, Day, Year)

and manner stated

1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28b. Time of Injury

, No	prior to co death? 1 □ Yes	cause	of

1 Natural 2 ☐ Accident 6 ☐ Could not be 3 Suicide

5 Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certi

Attendina MB

29d. Date signed (Month, Day, Year)

2008

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 12 4 31. Date filed (Month, Day,

State Registrar

Registrar's Signature Year) JUL 08 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Ce	ertificate of	Death		F	leg. No.	00 2100			
Physicia	an/	1. Decedent's Name (First, Middle,Last)				Date of Dea Month	Day Year	3. Time of Death			
Medical Exami		Jacqueline Elaine Roach				July 4, 20	08	1641 hrs			
		Facility Name (if not institution, give street and number) St. Agnes Hospital	4	b. City, Town, or I Baltimore	Location of	Death	4c. County of	Death			
			. last birthday)	If Under 1 Year	If Under	24Hrs 8 Date of Bi	4P (MM/DD/XXXX)	9. Birthplace (State or			
Funeral Director			60	Months Days			4/1947	Foreign Country) MD			
Director		214-50-6723 1 M 2XF.	60 _{Yrs.}	<u> </u>	1.9	0//1	4/194/	Country) 11D			
any .	H	Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ty. Town or Location	nn .				10d. Inside City Limits			
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yland F-f sh	횽	MD na I	Baltimo:	10f. Zip Code			10g. Citizen of Wha	27			
e Maryland or 28a-f show	Director			21229	.		U.S.A				
ith the Maryland 23a or 28a-f sho		3321 W. Caton Avenue 11. Marital Status 12. Was Decedent Ever in	U.S. 142 Wes			n? (Specify Yes or N		American Indian, Black,			
ath w	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Ye			Puerto Rican, etc.)	White,				
ter de		Black									
ors aff	3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)										
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21 be fill riked ent,	Randolph Aldridge Gertrude Johnson										
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica											
MC SIGHT ALL ALL ALL ALL ALL ALL ALL ALL ALL AL	Toby J. Roach—son 3321 W. Caton Avenue Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or										
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Page nent c											
rmit spartn spartn sports jury		21. Signature of Fundal Service Licensee		ame and Address		. 4300	Wabash	Avenue			
m 8 2 E E		Cynelle to price		arch Fi		E Balti	.more, M	D 21215			
Physician		23a. Part I. Enter the disease, or complications that caused the deafailure. List only one cause on each line.	ith. Do not enter th	e mode of dying,	such as car	rdiac or respiratory a	rest, shock, or hear	Between Onset and			
/Medical xaminer		Immediate Cause (Final disease a. Hypertensive Atheros		ovascular Dis	sease			Death			
		or condition resulting in death) Due to (or as a consequence	e of):								
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
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8760, tificate be ng physic as the bur	M/m	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of prediction 1 Live birth		tal death 3	Ectopic	pregnancy	23d. Date of d	Day Year			
Sox 68 leath certi e attendin for use a	cial	past 12 months? 4 Pregnant at time of	death -	ner (Specify)		p. og. c.,					
Box 68 e death cert the attendin	Physicia	1 Yes 2 No 9 Unknown 9 Unknown									
P.O. ss that the	Y	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause (given in Parl			oute to the cause of death?			
signe isigne	Q p	Chronic Renal Disease				_		Probably 4 🗸 Unknown			
ords, w requir as been s should	ete					24a. Wa		ere autopsy findings available for to completion of cause of			
eco te law te has ge 2 :	N F Denormed? death?										
tal Rec ian: The certificate ector, page		25. Was case referred to medical		26.Place	of Death (0	Check only one)					
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been side in by the funeral director, page 2 should be	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	✓ ER/Outpatient	3 DOA	Other ₄	Nursing Home 5	Residence 6	Other:			
n of ding Ph.	2	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of I	njury 28c. Inju	ry at Work?	28d. Describe	e how injury occurre	ed			
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/iSi rr Att ter de irrecte	lica	2 Accident Investigation 3 Suícide 6 Could not be 28e. Place of Injury - A	t home, farm, stree	et, factory, office b	ouilding, etc			r or Rural Route Number, City			
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F \$ F 0	ž	29b Signature and title of certifier		29c. Licens	se number		29d. Date signe	d (Month, Day, Year)			
		(La lubelle		O.C.	M.E.		July 5, 2008	3			
\sim		36. Name and address of person who completed cause of death (It									
\mathcal{O}		Laron Locke MD. Assistant Medical Examine		Street, Baltir	more, MD	D 21201					
	tate	0000 84-	ature A.	Si .		4					
Regis		JUL 0 8 2008 Marie									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death JULY 6, 11:38 A^M WILLIAM EDWARD RAPPOLD 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 28, 19 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1XM 2□F 1926 214-20-7050 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1XYes 2 No Florida Lee Fort Myers 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 33919 **USA** 4414 Spanker Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Gunnery Sgt. U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William (unk) Rappold Alma R. Ruzicka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Giglio / Dauhgter 1001 Dellwood Drive, Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 7-8-08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McComas Funeral Home, P.A. (ins 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsi's Du to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Cancer 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide

/Medical Examiner Vital

5 Hospital or Attending Division

use as t signed by t page After this within 24 hours arer death To the Funeral Director: filled in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral Director

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Examiner

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

Department of Health ar Important: If Item 27 is any injury or other trauonce.

Physician

Pages 1 and 2

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Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be Medical Certification: To 27. Manner of Death 1 Natural 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifie

> Guo, MD hesapeak Dr. Bel Air 21014.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Qinglin

31. Date filed (Month, Day, Year) 0 8 2008

gistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROSS TILLARD. Year **Physician** 2-08PM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth OCT 30, 1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min 1X M 2□ F 84 Maryland 217-18-1389 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 PNo Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3020 N. Ridge Road, Apt. W-214 21043 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Millard C. Ruth Bertha Weedon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104319a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Heatth and Important: If item 27 Is n any Injury or other traun once. 3020 N. Ridge Road, Apt. W-214, Ellicott City, MD Katherine Ross - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/7/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Steven H. Name and Address of Eacility Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cute disease or condition resulting in death) Wesky /Medical Due to (or as a consequence of) Examiner arcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to for sels consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed DIBEASE CORONARY 2 No 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident

requires that the death certificate be executed attending physician and for use as the burial-transit P.O. cate has been signed by the page 2 should be detached Division of Vital Records, certificate this funeral After Hospital or Attending

28a-f show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Modical Exprisher must be notified at

Saltimore, Maryland 21215-0036

alth and Mental H

Registrar

Certification: To within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

FUL 0 8 2008

6 ☐ Could not be

Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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D-30469

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

61 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** narles Ringgold LIVLY 1:05 06 2008 /Medical 4a. Facility Name (If not institution, give street and humber) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Maryland Baltimore Medical Center University 5. Social Security NumbeLINK if Under 1 Year | if Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**⊠**M 2□F 67 Director Mar. 6, 1941 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD 1 WYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 W. Franklin Street 21201 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 為反No Yes, Give 'ear or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 trackman B & O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Ringgold Alice Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly A. Worley / Nice 705 W. Lafayette Avenue; Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State txxBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Trinity Cemetery 07/12/2008 Baltimore, Maryland 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complishock, or heart failure. List only or ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myscardial Physician /Medical Due to (or 📥 a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to lor as a consequence of or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 □ No 3☐ Probably 4XUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? res 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient Certification: To 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 00,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. St. Baltimore, MD lared Grose Greene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 8 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 21866 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 1, Earl Vincent Roberts 2008 10:PM 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year) Min. 1**▼** M 2□ F Months Days Hours Sept, 18, 1924 Washington D.C 83 578.20.3130 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37058 Mallard Drive 19975 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Tyes 2 No If Yes, Give 1943-1945 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S Defense Mapping Elementary/Secondary (0-12) College (1-4or 5+) Map Maker Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeter M. Roberts Mary Catherine Miles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Roberts- Son 11029 Doxberry Circle.Woodstock, Md 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Martical Examiner must be notified at once.

Physician

/Medical

Examiner

10a. State

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12

Director

Funeral

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Completed

Be

Funeral

Director

show

death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

signed by the attending physician and be detached for use as the burial-tran cate has been signated by page 2 should b certificate

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Attending Physician;

State Registrar

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven July 8, 2008 Silver Spring, MD 22. Name and Address of Facility WitzKe Funeral Homes, 21. Signature of Funeral Service Licensee taleman 5555 Twin Knolls Rd. Columbia, Md 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONFESTIVE HEART FAILURE MONTHS disease or condition resulting in death) Due for as a consequence of) CORONARY ARTERY DISEASE 4EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnent at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed CHRONIC RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an 2**)**(No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64395 JULY 2, 2008

DHMH 17 Rev 1/2001

6545

Registrar's Signature

N CHARLES STREET, SWITE 209 BALTIMORE, MO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DUBERMAN, MD

0 8 2008

31. Date filed (Month, Day, Year)

			Registrar	tate of Maryland / De	partment of ertificate or	Health an f <i>Death</i>		giene 2008	8 21867				
46	Physicia /Medic	al	Decedent's Name (First, Middle, Last) Michael 4a. Facility Name (If not institution, give street)	Ros		or Location of D	2. Date of Dea Month	Day Year 6,2008 4c. County of Dea	3. Time of Death 6:40 A.M				
•	Examin Funeral		FutureCare-Nort 5. Social Security Number 6. Sex	n Point 7. Age (In yrs. last birthd	Eastpo	int r If Under 24	Hrs. 8 Date of Birth	Baltimo					
À	Director		212-18-9571	2 F 86 Yrs	-	s riouis in	Aug 19,	1921 Mai	rÿland 10d. Inside City Limits				
	th the Maryl or 28a-f sho e notified a)irector	Md . 10e. Street and Number		nore Cit			10g. Citizen of What C					
'n	ifter death wil ir items 23a c	Funeral Director	1 □ Never Married 2 □ Married	Was Decedent Ever in U.S. 1 Armed Forces? 1 TAYes 2 □ No	3. Was Decedent of If Yes, specify Cu	Hispanic Origin uban, Mexican, P	? (Specify Yes or No- ruerto Rican, etc.)	U.S.A 14. Race - Am Black, Whi Specify.Wh:	erican Indian, ite, etc.				
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show the the Medical Examiner must be notified at ent, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade co	f Yes, Give Year or Dates: In 16a De Impleted) (G College (1-4or 5+)		working	Specify: VIII						
and 212	d be filed with antal Hygiene ced other that cevent, the I	Be	7th 17. Father's Name (First, Middle, Last) Carmen Rossi	L.	aborer		Name (First, Middle,	Esskay Meats me (First, Middle, Maiden Surname) e Goldstein					
	i and 2 should be the alth and Mental I and 27 is marked of the traumatic every her traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every and the traumatic every ev	To	19a. Informant's Name/Relationship (Type. Rose M. Homberg 20a. Method of Disposition	/ Daughter 13	5 Laurel	Valle		er, City or Town, State, Abingdon 20c. Location - City o	, Md 21009				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healla and Mental Hygiene. Important: If it me 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		203. Method of Disposition 1 Burial 2 Scremation 3 Remote 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Bayvie	22. Name and Add	ory 7-	7-2008 aczorows	Baltimore ki Funera	e.Maryland al Home,P.A				
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commendate Cause (Final disease or condition		enter the mode of d			imore, Mo	d . 21222 Approximate Interval Between Onset and Death				
8760, 6	/Medical Examiner hysician and the burial-transit	fical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
.O. Box 68	The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	in the past 12 months?	If yes, outcome pf pregnancy 1□Live birth 2 □Fetal death 4□Pregnant at time of death 9□Unknown	3 ☐ Ectopic pregnal 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year				
a	equires that t en signed by uld be detac	by	Part II. Other significant conditions contrib	uting to death but not resulting in th	e underlying cause	given in Part I.		obacco use contribute	to the cause of death? Probably 44 Unknown				
al Records,	The lar	Completed					24a. Was autor perfo 1∐ Yes						
vision or Vital	ding Phy n. After this funeral d	ation: To Be	25. Was case referred to medical examiner? 1 Yes No Hosp 27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	ital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. In	Other: 4 Nursi	28d. Describe h	nne) dence 6 Other (Sp how injury occurred	ecify)				
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 2	Street and Number or F vn, State)									
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.										
•		2	29b. Signatifire and title of certifier			5772		29d. Date signed (Month, Day, Year) 07/07/09 US Crowd · MN 21234					
	HY Sta	te_	Marenda Bl. 31. Date filed (Month, Day, Year)	eted cause of death (Item 23a) (Ty 32 Registrar's Signature	pe, Print) 3 Wav baseler	Dram	Woods	frond. 1	UN 21234				
	Registr		JUL 0 8 2008	Blown St A	23421				•				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5.08 OLLISON 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 6. Sex 11. JM 2□ F If Under 1 Year Date of Birth (Month, Day, Year) May 22, 1944 5. Social Security Number **Funeral** Months Davs Hours 64 N.J 146-34-1666 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show r 28a-f sh notified 1 ☐ Yes 2 ☐ No Director PA Wayne Prompton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 2 must be n 18456 USA 109 Church St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married XX Married 3 Widowed 4 Divorced 1 □ Yes XX No altimore, Maryland 21215-0036 ş Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tool & Dye 12 <u>Purchaser</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard G. Rollison Florence Williams ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. 66, Prompton, PA 18456 Judith Ann Murphy Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h
Important: If ite
any injury or of
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Darling Cemetery July 8, 2008 Cherry Ridge TWP, PA Funeral Service L 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S, Glen Burnie, MD 21061 Gregory Approximate Interval Between Onset and Death 23a. Part1. Enter the d shock, or heart fai lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ne cause on each line. Immediate Cause (Final Physician PSIS disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner ung transplant Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequ P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be def Division or Vital Records, Ď 2 🗌 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2∏ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Tyes 4 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

GEOGGREY

29b. Signature and title of certifier

SHE WELD 32. Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08

Registrar

State

MO

29c. License number

D66335

Greene

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 126 per doc 881 7-8-08 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 8:58 AM **Physician** 02 JULY 2008 Sv1vester Carolyn В. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millersville Anne Arundel Assisted Living Well If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F Yrs. Maryland Director 23, 1922 216-12-3887 Usual Residence of Decedent 85 Nov. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examiliant nature to colling a 1 ☐ Yes 2 No Director Pasadena Marvland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 USA Funeral 845 Turf Valley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 11 O 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian 01son Daniel Copper ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7916 Kings Bench Place, Pasadena, Maryland 21122 Anthony R. Sylvester (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Pk. 07/09/2008 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Fureral Service Licenses McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 M 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner A pue law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as ase i 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy for L in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown ARTERY cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy The performe 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 XNo e Hospital or Attending Physician: 24 hours after death.
9 Funeral Director: After this certifica etely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 6 Rother (Specify) hospice Hospital: 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juite 204, miljesville, md 21108 , 2601 Ve Terans Hwy, MohitNegi

DHMH 17 Rev 1/2001

State

Registrar

Year)

0 8 2008

31. Date filed (Month,

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 1- State Registrar Amend 30 per DVR G881 7/8/08 eqfificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 15 /Medical am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pikesville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Number -12-0579 6. Sex. MX M 2 ☐ F **Funeral** Months Director 06 23 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notified at Y☐Yes 2☐No Director Baltimore MD na 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 U.S.A. 2334 N. Monroe Street Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status the Medical Examiner XYes 2 □ No 1 ☐ Never Married 2X Married Specify: Black Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: Yes, Give 1942-45 þ 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) <u>US Postal Service</u> 12th l yr Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Thomas Edward Stokes Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2334 N. Monroe Street Baltimore, MD 21217 Theodosia Stokes-wife 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Removal from State ō Department of Important: If it eny injury or conce. 07/11/08 Garrison Forest Owings Mills, 4 ☐Donation 5 ☐ Other (Specify) 21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue Baltimore, MD 21215 March FH West Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disese or condition resulting in death) Pnysician Cornestine /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence on) the Hospitel or Attending Physicien: The law requires that the death cartificate be exacuted al and Due to (or as a consequency burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 1 ☐ Yes 2 🗽 o 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of ath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Z Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I To Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03:2008

Registrar DHMH 17 Rev 1/2001

MIL

Sunlip Rajani, MD Pikesville, MD

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

30. Name and address of person

31. Date filed (Month, Day, Year)

21871

			For State Registrar	ie oi maryiano / i	Certificate of		Reg.		21071	
	Ph ! - !		Decedent's Name (First, Middle, Last)	•			Date of Death	Day Year	3. Time of Death	
	Physicia /Medic		PHILLIP				Month VLY	02 2000		
	Examin	er	4a. Facility Name (If not institution, give street a			r Location of Death		4c. County of Death	1	
22	Funeral		Bon Secours Hospi 5. Social Security Number 6. Sex	7. Age (In yrs. last bii	thday) If Under 1 Year	timore If Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign	
- 1	Director		212-48-4396 ¹ X ^{M 2}	□ F 60	Yrs. Months Days	Hours Min.		47	intry) MD	
	pug s		Usual Residence of Decedent 10a, State 10b, County	10c. City, Tow	n or Location				10d. Inside City Limits	
	Maryla f sho	ō	MD NA	Ba	ltimore				1 XYes 2 No	
	r 28a- notif	irec	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?	
	th with	Funeral Director	1925 East Belverd			21239		U.S.A		
	er dea tems ner mo	nue	Arı	is Decedent Ever in U.S. med Forces?	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Specify an, Mexican, Puerto Ric	Yes or No- an, etc.)	14. Race - Amer Black, White		
36	rs afte		1 ☐ Never Married 2√2 Married 1 ☐ If \(\) 3 ☐ Widowed 4 ☐ Divorced Ye	XYes 2 ☐ No es, Give ar or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	Black	
20 AS Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade comp	16a	. Decedent's Usual Occup (Give kind of work done	ation	16	b. Kind of Business/l	ndustry	
2	ithin 7 ne. "nan" e Med	mple	Elementary/Secondary (0-12) Co	llege (1-4or 5+)	life. DO NOT use retired	d)	G.	ahool Su	atom	
25	illed w Hygiei ther ti nt, th		12th grade n 17. Father's Name (First, Middle, Last)	aB	uilding Su	18. Mother's Name (F		chool Sy iden Surname)	stem	
N C	ld be fental ked or	To Be	Phillip Snow Sr.			Gladys Fo	rther	оу		
2	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Pri	int) 19t	o. Mailing Address (Street	and Number or Rural R	oute Number, C	City or Town, State, 2	(ip Code)	
3 3	and 2 ealth a n 27 i		Edna Snow-Wife	1	925 East F	Belverdere	Ave,	Baltimor	e, Md 2123	
0/C	ges 1 t of H if iter		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Remova	cemete	rv. crematory or ether pla	ce) !		,		
0	it. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee	DAKE	ISON FORE		00 14	NTM CONTIN	USIN	
a a	perm Depa Impo any i		21. Stream of the lead of the Elderise	Halam	March F/F	H West ash Ave, H	0 - 1 + i m	bM oxo	21215	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do	not enter the mode of dyl	ng, such as cardiac or re	espiratory arrest	t,	Approximate Interval Between	
	Physician	r i	Immediate Cause (Final disease or condition	HEPATIC	ENCE	PHALOPA	THY		Onset and Death	
9	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	. = 0	1501	_		
- 1		-	Sequentially flat conditions, if any leading to immediate	HEPATIC Due to (or as a consequence END 570 Due to (or as a consequence	of):	IEN DI) 4 M 9 6			
	ansit and	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	RTERIOSCI	EROTIC	HEART	273	EASE		
0	an an	Exa	resulting in death) Last	Due to (or as a consequence	of):					
68760	rtificate be executed ng physician and as the burial-transit	edical	d							
	certific ding p	/Med	IF FEMALE: 23c. If y	ves, outcome pf pregnancy				23d. Date of del	iverv	
Box	The law requires that the death cer tee has been signed by the attendin bage 2 should be detached for use	Completed by Physician/M	in the past 12 months?	□Live birth 2 □ Fetal deat □Pregnant at time of death	h 3 □Ectopic pregnanc 5 □ Other (specify) _	у		Month	Day Year	
C	t the c by the	hysi	9 Unknown	⊒Unknown						
Records P.O.	es tha	by P	Part II. Other significant conditions contribution - HYPERTE		in the underlying cause given	ven in Part I.			o the cause of death? robably 4 Dunknown	
Ž	requir	sted			15					
A Page	2 as a	mpl	- SUBSTAN	CE MAG			24a. Was an autopsy performe	ad? death?	utopsy findings available completion of cause of	
	an; Th tiflicate or, pa	e Co	25. Was case referred to medical	TMI LUX		26. Place of Death (4	2 □ No	
or Vital	hysicia this cer al direct	To Be	examiner? 1 ☐ Yes 2 X No Hospita	al: 1 Inpatient 2 ☐ ER/O	utpatient 3 DOA Oth	nor:		ce 6 □Other (Spe	cify)	
	Attending Physician: r death. ector: After this certific. by the funeral director.	L:uo	27. Manner of Death 1 X Natural 5 □ Pending		Time of 28c. Inju No	rk?	I. Describe how	injury occurred		
Livision	ttendi	cati	2 Accident investigation 3 Sulcide 6 Could not be	Place of injury - At home f		Yes 2 No	Location (Stre	et and Number or B	ural Boute Number.	
اًلا إِذَ	I or Attendatter death	Certification:	3 Suicide 4 Homicide 4 Homicide 5 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: C	: To the best of my knowledg	e, death occurred at the t	ime, date and place, and	d due to the cau	use(s) and manner a	s stated.	
	the Hin 24 the Fi	Medical	one) a	nd manner stated.						
	T vity	2	29p. Signature and title of certifier	Haller	290. Liden:		290	TALL SIGNED (WORK	2 2 AA	
	J 1/	1	30. Name and address of person who complete	ed cause of death (Item 23a)	(Type, Print)	23500	05 2	DAP.	c Zoox	
	51	1	29b. Signature and title of certifier 30. Name and address of person who complet \$\(\subset \mu\) \text{PATE} 31. Date filed (Month, Day, Year) JUL 0 \(\subseteq \) 2008	2L 2000	W. 13A2T	0.3T, X	BALTO	MD: 2	1223.	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	hand.					
	Registr	rar	10F 0 & 5008	Person S.	Regards					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY Month **Physician** 2008ª 9:45 P.M SAMUEL URBAN SCHULTZ 3, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner OAK CREST CARE CENTER BALTIMORE PARKVILLE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months M∏M 2□F 5/24/1901 Director MARYLAND 212-03-6261 107 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE PARKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 7845 WENDOVER AVENUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Iral", or item Examiner n Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: WHITE 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ YEARS ATTORNEY COMMUNICATIONS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental MARY R. CAMPBELL SAMUEL J. SCHULTZ ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7845 WENDOVER AVE. BALTIMORE, MD 21234 FRANK BRADFORD/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State NEW CATHEDRAL CEM. 7/8/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. TOWSON, MD 21286 8521 LOCH RAVEN BLVD. Approximate Interval Between Onset and Death P-rt1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chronic Obstructive Lung Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1:44 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use to for as a consequence of Examiner sician and burial-transit De mentia Due to (or as a consequence of): ng physician a Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 X No eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HO 0 52365 JULY 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Path ville Maryland 21234

Rorald Teffreys 880 Walther Bodevard Path ville Maryland 21234 Te ffreys 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 8 2008 Registrar

DHMH 17 Rev 1/2001

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

MMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State	of Marylar		artment of h <i>tificate of</i>		d Mental H	ygiene	2008	21873	
			Registrar 1. Decedent's Name (First, Middle	e, Last)		001	- Inoute or	Dodin	2. Date of D			3. Time of Death	
	Physici /Medic			Vane	ssa J.	Silve	er		Month 6	30 ^{Day}	2008	5:33 P M	
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	r Location of D	eath	4c. C	County of Death		
			University				Balto				N/A		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🙀 F	7. Age (In yrs. 50	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 h	Min. 8. Date of B	irth <i>0ay, Year)</i> - 1958	9. Birth	place (State or Foreign ntry)	
	Director		219-70-2573 Usual Residence of Decedent	Λ	50	115.			5-27	-1958	3	MD	
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation		-		1.	10d. Inside City Limits	
	Mar a-f sh	tor	MD N	/A	В	altimo	ore					X XYes 2 ☐ No	
	or 28,	Jire	10e. Street and Number				10f. Zip Code	01016		_	en of What Cou	ntry?	
	23a	ral	1811 N. Wa	rwick A	venue			21216		τ	J S A		
	ir dez	Funeral Director	11. Marital Status	Armed F	cedent Ever in U orces?	.S. 13. \	Vas Decedent of F f Yes, specify Cub	Hispanic Origin? an, M <i>e</i> xican, Pu	? (Specify Ye's or N uerto Rican, etc.)	10- 14	 Race - Ameri Black, White, 		
30	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Modical Evantrac must be notified at	by F	1X Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 ∐Yes If Yes, G Year or I	2 □ No Biv X X Dates:	1	□Yes 2 🛭 No	Specify:		5	Specify: Bla	ack	
215-UU36	2 hou	ted	15. Deceden	t's Education		16a. Dece	lent's Usual Occup	pation		16b. Kind	d of Business/In	dustry	
2	e. an "n	Completed	(Specify only highes Elementary/Secondary (0-12)	-	(1-4or 5+)	(Give life. L	kind of work done OO NOT use retire	during most of d	working				
7	ed wit	Con	10th grade		N/A	Dis	abled				sabled	l	
yland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle,	,				18. Mother's I	Name (First, Middi	e, Maiden S	urname)		
<u>\</u>	ould Mer narke	으	Herman Silv						ther Wi				
<u> </u>	12 st th and 7 is n traun	l W	19a. Informant's Name/Relations Robert S. Si	, , , ,	other	1	•		r Rural Route Num Avenue			,	
a,	1 an Heal tem 2		20a. Method of Disposition	TVCL DE	20h 8	Place of Dieno	eition (Name of		Date		ation - City or To		
Daltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.		XXBurial 2 ☐ Cremation 4☐ Donation 5 ☐ Other (S)		State T	cemetery, cren Cinity	cemete	ery 7-1	7-2008	Balt	o, MD		
	oortar		21. Signature of Funeral Service				. Name and Addre	1	March 1	l Fagt	F/H		
Ď	De E		Condrae h	Mitax	fol-	_ 1	101 E.	North	Avenue			21202	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat							Approximate Interval Between	
-	Physician		Immediate Cause (Final disease or condition		Sep	212						Onset and Death	
	/Medical Examiner		resulting in death)	Due to	(or as confeq	juence of):	1						
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5	exection and and ial-tra	Examiner	resulting in death) Last	c Due to	(or as a conseq	uence of):	· ·						
0/00,	icate be executed physician and the burial-transit	dical		d									
8	ertifica ing ph	Med	IF FEMALE:										
Š	ath ce	ian/l	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 Feta	al death 3	Ectopic pregnanc	су		23	3d. Date of deliv Month	ery Day Year	
- 5	e law requires that the death certifi has been signed by the attending e 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Preç 9 ∐ Unk	gnant at time of one of the contract of the co	death 5∟	Other (specify) _						
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Č,	uires n sigr lld be	d by	-HIV						_ 10]Yes 2□	No 3□ Pro	bably 4 Luknown	
0.00	s bee	Completed							24a. Wa		24b. Were auto	opsy findings available	
ב	The is te ha	m o							per	opsy formed? 2 DNo	prior to co death? 1 ☐ Yes	empletion of cause of	
2	ilcian: The certificate ector, pag	0	25. Was case referred to medical examiner?					26. Place of I	1 ☐ Yes Death (Check only		I Lites	Z LINO	
5	Physic this ce al direc	70 B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2□	ER/Outpatien	t 3 □ DOA Oth	ner: 4 🗆 Nursin	ng Home 5 ☐ Re	sidence 6	□Other <i>(Speci</i>	fy)	
5	ing Physician: The n. After this certificate h funeral director, page	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date (Mor	e of Injury nth, Day, Year)	28b. Time of Injury	28c. Inju	k?	28d. Describe	how injury	occurred		
2	• Attend er death • ector: / by the f	icati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be	a of Injury . At h	ama form atra		Yes 2 □No	OOf Location	(0111	Muss bases of Con-	-t D- eta Alemahan	
5	lor A after Direc I in by	Certification:	4 ☐ Homicide determ	ned 20e. Flace	ding, etc. (Special	fy)	eet, factory, office			(Street and own, State)	Number or Hur	al Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifyin	g Physician: To th	ne best of my kno	owledge, death	occurred at the ti	me, date and p	lace, and due to th	e cause(s)	and manner as	stated.	
	the Ho nin 24 the Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	5 v v iii	Σ	29b. Signature and title of perting	$\nearrow \mathscr{A}$		110	29c. Licens		,		signed (Month,		
			111/school	ancha	Kenn	IVI) //	-1171	/	Jun	e 30	2008	
	7		30. Name and address of payson	who completed cau	how i	22 .	S. Gree.	no s	! Z., Bai	himora	MI	21201	
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature	A		, June	.7. 016	· W	-1601	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20081 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2:00 AM war JUK 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Saltimore summit 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 8. **Funeral** 1**∭** M 2□ F Months Days Hours Min. Director An Diego, CA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modifical Examinar must be notified at any injury or other traumatic event, if a Modified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 🗷 No rkuill altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 🕱
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hutomotive Elementary/Secondary (0-12) College (1-4or 5+) ecialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8600 athe usel Jummit 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lans Proecal Crapel & Cremations 21. Signature of Funeral Service License 8800 Harford Road Parkville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HOCCIRTIC 10 nim TUESTON /Medical Due to (or as a consequence of) **Examiner** 1ears Sequentially list conditions, if ny Lain cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of The law requires that the death certificate be executed burial-tran P.O. Box 68760, Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be es 124 hours after death.

e Funeral Director: After this certificate has been signed by the attending physician letely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 Z No 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division **Natural** 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4460' 5 Name and address person who completed cause of death (Item 23a) (Type, Print) Parkulle 1 CHAEZ HARFORD Rd 31. Date filed (Month, Day, Year) gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Doris Evelyn Sprucebank July 3, 2008 10:55 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🗆 M Months 212-26-5784 80 Director 2, 1927 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, it a Medical Examiner must be notified at 1 TYes 2 No Baltimore Director Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1644 Naturo Road 21286 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes XXNo Specify þ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic ev William Henry Fleetwood Mary Elizabeth Kelbaugh ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Lee Speca Daughter 138 N. East Avenue, Baltimore, MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 7/7/2008 Eldersburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Easer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** WEEKS /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Gacquentiasy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician law requires that the death certificate be Physician/Medical Box 687 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 DeNo o signed by the 9 🗆 Haknowa 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Records, ð ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? The certificate Division of Vital Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ၉ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ال 24 hou، در 24 hou، در 46 Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 ho

To the Fun

completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JULY 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

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Registrar | | | | 0 8 2008

31. Date filed (Month, Day, Year)

DANIEUE DEBERMAN, MO

32 Registrar's Signature

Jake 1

6565 N CHAPLES ST, SUITE 209

BALTIMENE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SAPPINGTON 9:40 AM OHN 2008 Sull /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 F Days 220-56-1441 June 26, 1953 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Baltimore 10f. Zip-Code 10g, Citizen of What Country? 10e. Street and Number death with 4507 Prospect Circle 21216 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". or any injury or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify. Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Life Insurance Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B Orval Sappington Marie Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A.C. Carroll Partner 4507 Prospect Circle; Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7/8/2008 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signatur of Fundami Service Jaco 1630 Edmondson Avenue; Catonsville 21228 23a. Part 1. Enter the disease, or complications that pedsed the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, MRSA pneumonia

Due to (or as a consequence of): Physician disease or condition resulting in death) weeks /Medical Examiner disease versus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ymphomo or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the use as t 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No signed by the at id be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21 No 3 ☐ Probably 4 ☐ Unknown 1 TYes certificate has been sig lirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 Yes 26. Place of Death (Check only one) director 25. Was case referred to medical Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 1 Tes ၉ After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Af 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound to the completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 JENNIFER ANN 600 North Wolfe St, Baltimore, MD, 21287 YA" 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,20b per fb c881 7-8-08 vt. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month 20 AM Alma Simpson Sharpe /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Battmort Security Number If Under 24 Hrs. Funeral 6 Sex 8. Date of Birth (Month Day, Year) 09/01/1925 Birthplace (State or Foreign Country) 1□M 2▼F Months 061-22-2796 82 Days Hours Min. Director NY Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination to refilted at once. 10d. Inside City Limits MD Baltimore Director Rosedale 11√ Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 19 Paula Place , Apartment 2B 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 XX No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black ģ 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last)
Francis C. Si 18. Mother's Name (First, Middle, Maiden Surname)
Wilhelmina Bright Be Simpson Bright ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivy Sharpe Morris / Daughter 19 Paula Place, Apartment 2B, Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 B Removal from State Memory's Garden Cemetery 07/00/2008 4 ☐ Donation 5 ☐ Other (Specify) Colonie, NY 21. Signature of Funeral Service License 22. Name and Address of Facilify Dorota Marshall Charles L. Stevens Funeral Home Inc. 1501 East fortAvenue, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** oronari disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of/ physician and stransit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Lectopic pregnancy Month signed by the a Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use ontribute to the cause of death? Completed by page 2 should 1 ☐ Yes 2 🗹 No 3 Probably 4 Unknown has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate perform 1 □ Yes 2 MNo 1 ☐ Yes 2 🗆 No Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 V Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Dr. Baltimore, MD Square 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 08 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ′ზ7 d4³ **2008** James Edward Stevenson, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Genesis Eldercare Loch Raven Center Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday 1 X M 2 □ F Maryland 92 213-10-0182 10/28/1915 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🙀 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 8810 Rossville Blvd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Mass Transit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward Stevenson Bessie E. Jacob 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Stevenson, Jr., Son 2615 Lawson Road, Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 07/07/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked otherly Injury or other traumatic event

Physician

Examiner

Funeral

Director

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Director

<u>چ</u>

Completed

Be

Examine

Physician/Medical

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Completed

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 been signed by the should be detached

page 2

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate h completely filled in by the funeral director, page

State Registrar

resulting in death)	Due to (or as a consequence of):	_Teb)[
Sequentially list conditions, included in the cause. Enter University of the cause. Observed or injury	b		
Cause (Disease or injury that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 🌠 Unknown
_		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ※No
25. Was case referred to medical examiner?		ath (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Matural 2 Accident Accident Accident	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could not lead to determine determined		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)

Reg. No. 2008 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** SIMMONG ROJE 0 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE ROLAND PARK MD BALTINORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 231-22-0113 1 □ M 2 🙀 F Director Jan. 7, 1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at MD Director **Baltimore** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a or 633 Aisquith Street Apt. 16B 21202 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cook Bernard Restaurant permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: if item 27 is marked other than any injury or other traumatic event, in once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Burnett Granner Mary Granner ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tamara Peterson / Friend 2309 Ashburton Street; Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 07/10/2008 Woodlawn Cemetery Wppdlawn, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licenses 638 N.Gilmor Street; Baltimore, Maryland 21217 23a. In t1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lip only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** emont /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Month 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Hiknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate 1 ☐ Yes 2 **∃**1√0 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours and.

To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

821

32. Registrar's signatur

N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Yea

09

10:00 PM

Birthplace (State or Foreign Country)

VA

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 ☐ No

6

ST Inte 308 BALTIMOREMI

1√Yes 2 No

Registrar DHMH 17 Rev 1/2001

State

ENTAW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland / I	Depa <i>Cer</i>	rtment of H	lealth and Death		giene	2008	21880		
			Decedent's Name (First, Middle, L.)	ast)					2. Date of De	ath	Van	3. Time of Death		
	Physici /Medio		JEQUETTA LYNN	SUTTON-GRE	EN				JULY	2, ^{Day}	008 Year	2:50AM		
	Examir	er	4a. Facility Name (If not institution, ga		D		4b. City, Town, or		ath	4c.	County of Death	1		
	Euparal	ist.	FUTURE CARE NUE 5. Social Security Number 6.	Sex 7 Ag	R e (In yrs. last bii	irthday)	BALTI If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th	place (State or Foreign			
	Funeral Director		220-84-2124	1□M 2\ F	44	Yrs.	Months Days	Hours Mi	n. (Month, Da 3-1-	1964	M.	place (State or Foreign intry) RYLAND		
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Lor	ation					10d. Inside City Limits		
	Marylan f show isd at	ō	MD. N/A			TIMO					- - - -	1 ☐Yes 2 ☐ No		
	r 28a-	Irect	10e. Street and Number		DAL	TITE	10f. Zip Code			10g. Citi:	itizen of What Country?			
	th witi	aiD	850 W. FAYETTE	ST.			212	01	-		USA			
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Evantinet must be nutilised at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		lf If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.))-	14. Race - Amer Black, White Specify: BI			
5-0	72 h	etec	15. Decedent's I (Specify only highest g	Education rade completed)	pleted) (Give kind of work done during mos				vorking	16b. Kir	nd of Business/l	ndustry		
2121	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5			SEKEEPING			DO	DOMESTIC			
	il Hygid other vant, ti	a	17. Father's Name (First, Middle, Las			11000	, BRIBEI ZITO		lame (First, Middle	le, Maiden Sumame)				
/lar	S should be filed withir and Mental Hygiene. Is marked other than aumatic evant, the Man	To B	BOBBY L. SUTTO	N				MAR	THA CLIF	TON				
, Maryland	permit. Pages 1 and 2 sho Department of Health and Important: if item 27 is m any injury or other traum onge.	19a. Informant's Name/Relationship (Type, Print) MICHELLE RAY (SISTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or 850 W. FAYETTE ST. BALTIMORE, M.												
Baltimore,	Pages 1 nent of He int: if itan		20a. Method of Disposition 1 □ Burial 2 □ XCremation 3	☐Removal from State	cemete	ery, crem	atory or other plac		Date	20c. Lo	cation - City or 1	own, State		
iţi m	permit. Pa Departmen Important: any injury once.		' 4 □Donation 5 □ Other (Spec				EMATORY	1	-2008			MARYLAND		
Ba	permit. Departr Imports any inji		Jerott HiBrer 1721-27 N. MONROE ST. BALTIMORE, MARYLAND											
		23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shear, or heart failure. List only one cause on each line.												
	Physician /Medical	dicat resulting in death)												
	Examiner			Due to (or as	a consequence	01):								
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):								
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dua to /or oc	a consequence	of):						1		
68760,	ficate be executed physician and s the burial-transit	aiE		20010 (01 43	a consequence	01).								
687	ifficate g physas the	ledicai		d										
P.O. Box	The faw requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			2	23d. Date of deli Month	very Day Year		
	res that igned to be deta	by P	Part II. Other significant conditions	contributing to death b	ut not resulting	in the un	iderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?		
ord	w require been si should	ted	Hyporten	was C	wor	u	Rina		- 10	Yes 2[□No 3□Pro	bably 4 Munknown		
of Vital Records,		Completed	Laulu	ri							prior to death?	topsy findings available ompletion of cause of 2☑ No		
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			2 DDA Oth	0.0	eath (Check only					
	ding Phys The After this funeral di	n: To	1 ☐ Yes 2 € No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Da	nt 2 ☐ ER/O	Time of	28c. Injun	4 ps Nuising	Home 5 Res 28d Describe			efy)		
ion	Attending or death. actor: After by the fune	atio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigati		y Year)	Injury		k? Yes 2 □ No						
Division	ai or Atte s after de ni Diracto								28f. Location City or To			ral Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext	hysician: To the best iminer: On the basis of and manner sta	examination at	je, death nd/or inv	occurred at the ting restigation, in my o	ne, date and pla pinion, death oc	ace, and due to the courred at the time	cause(s) , date and	and manner as I place, and due	stated. to the cause(s)		
	To the To the Comp	Σ	29b. Signature and title of certifier	0141 11			29c. Licens				e signed (Month	Day, Year)		
,	4			PHYSIC				7543		7-	- 3-0 8			
2				mp 19	40 W	, B	ALTIMO	RE ST	. BA	L7/1	WRE,	np 21223		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature											

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

1-

10a. State

Md.

Physician

Examiner

Funeral

Director

/Medical

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760

Medical Certifica

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Malika F.

JUL 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Waseem, M.D.

2. Registrar's Signature

Funeral D	430 Gusryan Street		21224		U.S.A	•					
ner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. W	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit						
by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		∃Yes 2□No Specify:	,		White					
Be Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	nt's Usual Occupation	rkina I T	b. Kind of Business						
를	Elementary/Secondary (0-12) College (1-4or 5+)		ind of work done during most of wo D NOT use retired)		istille	ur Roses					
S	12th	12th									
To Be	17. Father's Name (First, Middle, Last) William Beall			me (First, Middle, Ma. Phillips							
Г	19a. Informant's Name/Relationship (Type. Print)	_	Address (Street and Number or R			•					
	Ms. Debra Gnibus/niece		Wampler Road	Baltimor	e, Md.	21220					
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	lace of Disposi emetery, cremi	tion (Name of atory or other place)	Date 20	c. Location - City or	Town, State					
	4 □ Donation 5 □ Other (Specify) St		slaus Cem 7-9								
	21. Signature of Funeral Service Licensee		Name and Address of Facility a C								
	Tolal Vector		01 Dundalk Av								
	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not enter	the mode of dying, such as cardia	c or respiratory arrest	t,	Approximate Interval Between Onset and Death					
	Immediate Cause (Final disease or condition resulting in death) List only one cause on each line. Cardiac Arrhyth wias Due to (or as a consequence of): Cardiac Arrhyth wias Due to (or as a consequence of):										
	Due to (or as a consequence of the control of the c	uence of):	Astonia Di	1892		un-known					
<u>.</u>	if any leading to immediate b. Due to (or as a consequence)		7) 0019								
ji.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	defice of).									
xan	that initiated events resulting in death) Last Due to (or as a consequence of the consequ	uence of):									
ical	d										
Mec	IF FEMALE:				1						
ian/	23b. Was decedent pregnant in the past 12 months?	ıl death 3 □E	Ectopic pregnancy		23d. Date of de Month	livery Day Year					
sic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown 4 ☐ Pregnant at time of d	eath 5∐	Other (specify)								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?											
ed by	HTM, DM, C	HF.	, COPD	1 ☐ Yes	2 No 3 P	robably 4 dinknown					
Section Due to (or as a consequence of):											
											Be
2	1 Yes 2 No Hospital: 1 Inpatient 2					stedLiving					
lification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Accident State of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M1 □ Yes 2 □ No	28d. Describe how	injury occurred						
tifice	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At he building, etc. (Specification)	ome, farm, stre	et, factory, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,					

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D038754

709 Eastern Blvd. Baltimore, Md. 21221

July 7,

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State Registrar		State of	of Marylan		artment rtificate				lental Hy		711118	21882
			_	Registrar 1. Decedent's Name (First, Michael Control of the	idlo Last			06	lincate	, OI L	Jeani		2. Date of De	Reg. N	10	3. Time of Death
	н	Physici	an	Bert F. Spa		/							Month	D	ay Year	
		/Media			-				45 City T		Lanation	of Dooth	July 3		2008 Ic. County of Death	1:50 p M
		Examir	er	4a. Facility Name (If not institute Harford Mem-	-						Location of			1		
				5. Social Security Number	6. Se		7. Age (In yrs.	last hirthday	Havre				9 Date of Ric		larford	lana /State or Foreign
		Funeral		219–16–9578		X XM 2□F	84	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da	y, Yea	r) Coun	lace (State or Foreign
		Director		Usual Residence of Decedent			04						UCL.	40,1	1923 Penns	syrvania
		land		10a. State 10b. Cour	ity		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
0		Mary i eh	ō	MD Ha	rfor	đ		White	Ford							1 ☐ Yes 24 ☐ No
13		288	rec	10e. Street and Number	LIOI	<u> </u>		WILLCE	10f. Zip (Code				10g. C	Citizen of What Cour	itry?
(A)		3a or	0	4314 Prospect	Road	d			211	60				US	SA	
		within 72 hours after death with the Maryland ene. then "neturel", or ttema 23a or 28a-f ehow he Madical Examiner must be malified at	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in U	S. 13.			spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Americ	
1º	(0	r He	Fu	1 Never Married 2 M	arried	Armed Fe 1 ⊠ Yes	2 🗆 No						Rican, etc.)		Black, White,	
Ja	93	urs a	by	3 ☐ Widowed 4 ★ Divorc	ed	If Yes, Gi Year or E	ve Dates:		1 Yes 2	IXI No	Specify:				Specify: Whit	e
15	21215-0036	within 72 hours after ene then "neturel", or ite he Madical Expression	Completed	15. Deced	ent's Edu	ucation		16a. Dece	dent's Usual	Occupa	ation	t of work	na	16b.	Kind of Business/Inc	dustry
145)	215	hin 7	ple	(Specify only high		College (life.	kind of work DO NOT use	e retired))	t OF WORK	ng	B.		
7	21	d will	50	Elementary/Secondary (0-12		,		Facto	ory Wo	rkeı	r			DI	rewery	
3		al Hy al Hy I oth	Be	17. Father's Name (First, Middle									(First, Middle		en Sumame)	
1	<u> a</u>	Vants	20	William J. S	Spare	е					An	na C	. Becke	er		
8	Maryland	es 1 and 2 should be filed within of Health and Mental Hygiene. If tem 27 is marked other then ir other treumatic event, the Me		19a. Informant's Name/Relatio	nship (T)	ype, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City	v or Town, State, Zip	Code)
7-		and 2 alth 27 I	1	Bert W. Span	re- S	Son		PO Bo	x 401	3 St	ın Va	11ey	. AZ 86	029		
3	Baltimore			20a. Method of Disposition	- 00	7	20b. F	Place of Disponentery, crea	osition (Name	e of her place	e)		Date		Location - City or To	wn, State
1	Ĕ	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☑ Crematio 4 ☐ Donation 5 ☐ Other				ro Cre				7/7/	2008	Ba1	timore, M	aryland
	alti	그는문증	1	21. Signature of Fun ral Service	ce Ligens	199		2:	2. Name and	d Addres	s of Facilit	y Ch.	arles S	. Z	eiler & S	on
	m	Depermine Depermine Important Irraportant		11400	2			62	224 Ea	stei	en Av	enue	Baltin	ore	, MD 2122	4
				23a. Purt1. Erter the disease, shick, o heart failure.	comp	lications that	caused the deat	h. Do not en	ter the mode	of dying	g, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Between
		Physician		Immediate Cause (Final	isionly	X .	aci inio.	-	Pho	6 A 4=	. D.,		11	1		Onset and Death
		/Medical		disease or condition resulting in death)	-	a. Due to	(o) as a consec	JOh-	1116	un	10n	14	WIT	h-	-	
		Examiner				3	,		R,	260	آخيرا ا	600	11 F		110	
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V		uted d anslt	Examiner	Cause (Disease or injury	1	с.						V.				
	o	ate be executed nysicien and he burial-transit		resulting in death) Last	1		(or as a conseq	uence of):								
+	760	ysicie	cal			d										
>	99	certifica Iding ph	ed											-		
90	Вох	h cer endin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	- 2		tcome of pregna		∃Ectopic pre						23d. Date of delive	ery
(47)	<u> </u>	deat e attr	10	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 Preg	nant at time of d		Other (spe						Month	Day Year
100	0.	at the by th tache	hys	9 Unknown		9□ Unkn	IOWII									
Y	S, F	es that the death certifica igned by the attending ph be detached for use as th	by F	Part II. Other significant cond	itions 90	ntributing to d	leath but not res	ulting in the u	nderlying ca	use give	on in Part I	7 .	23e. Did	tobacco	o use contribute to the	ne cause of death?
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Q-	Record	> A 50	Completed	Calal	. D.	201196	LL	, }	}				24a. Was		24b. Were auto	psy findings available
5		The lav	E	Cara	101	1701	17.17	7 -					auto perf	ormed?	death?	mpletion of cause of
	tai	ician: Th certificete rector, pag	BeC	25. Was case-reterred to medi	GIV!	PAI	ery	DIS	ease	1-	26 Place	of Death	Check only		40 10165	21,0140
	>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	/	Hospital:	Inpatient 2	ER/Outpatie	nt 3 🗆 DOA	A Othe	200				6 ☐Other (Specif	(v)
	Division of Vital			27. Mann of Death	-		of Injury oth, Day Year)	28b. Time o		Bc. Injury Work			28d. Describe			,,
	Ö	Attending F r death. ector: After by the funer	atio	1 ☑ Natural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(NIOI	iui, Day 19ai)	Injury	м		Yes 2	No				
	<u>Vis</u>	Atte	€	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	id not be	289. Place	e of Injury - At h	ome, farm, st	reet, factory,	office		1	28f. Location ((Street	and Number or Rura	A Route Number,
	ā	s after or or or or or or or or or or or or or	Certification:	4 _ Hollicide		Dullo	ing, etc. (Specil	y)					City of 10	IWII, SIZ	4(9)	
		To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Medic	ying Phy	sician: To the	e best of my kn	wledge dast	h conumed a	it the tim	va, date an	d (lana)	and due to the	causa	(s) and manner as s	tated
		he H in 24 he F plete	Medical	one)	er caarn	and mar	ner stated.	and and or in	vestigation,	m my of	JIIION, 008	un occurr	eu at the time.	, uate a	and place, and due to	o me cause(s)
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	1	140		30. Name and address of pers	on who c	ompleta to u	se of death (Iter	n 23) (Type,	Print)		1 -	1	+ 41	-	1/ /	1 21001
	1	0.		Manuel	17	11	M	D	8 10	in	CT	ree	LA6	ev	deenVla	vyand
		Sta		31. Date filed (Month, Day, Ye		008 32.	egistrar's Sign	L	10	-			/		/	/
		Registi	ar	JUL U	0 4	100	William.	15 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 Physician 6, 5:30 P M Ju1y Zelma Lee Thorsen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Pikesville Springhouse Assisted Living Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Funeral 1 □ M 200 90 June 10,1918 Maryland Director 216-01-6198 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes XXNo Pikesville Funeral Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21208 Apt. 518 130 Slade Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes XX No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White Completed by XXWidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Daugherty Lacy Ashmead မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 77 River Oaks Circle, Baltimore, MD21208-1365 David A. Lambert / Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State 7/8/08 Baltimore, MD Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Emeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 mu asline 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovasco lar **Physician** Atheroscleratio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, 5 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Month Day in the past 12 months? 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Nonknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 | Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7/08/2008

Regultrat

State

D. Martin

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ASSC N

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32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Geraldine F. Thomas 3:30 a M 4 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1921 Oakhill Avenue Balto N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2√ F Hours Min. 96 Director 220-14-2113 4-20-1912 VA Usual Residence of Decedent 10d. Inside City Limits show 10a, State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinating as to notified at 1 Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 S Α 72 hours after death 1921 Oakhill Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give X 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify Black \$ 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Disabled 3rd grade 17. Father's Name (First, Middle, Last) Disabled 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fill h and Mental H is marked ot Unk Mabel Street ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health ar item 27 is Gladys Thomas-Daughter 1921 Oakhill Avenue Balto, MD 21218 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 7-10-08 Baltimore, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 ondras 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cations ereprovasou **Physician** disease or condition resulting in death) OMP 1011412 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2√2No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) me men 31025 12 30. Name and address of person who completed cause of death (IJem 23a) (Type, Print) 80 D 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMD TIP#23pt I line perfits. C881 / 808 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2008 Year **Physician** Month June 26, 8:40 PMM <u>Jane M. Terhune</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Towson The Gilchrist Center
5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1□M 2**Ø**F Yrs Director 83 1924 New York City 29. 147-14-6878 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is it is a constituted at 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County Director 1 X Yes 2 No Baltimore MD. 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21210 103 W. 39th Street Apt. A1 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X☐ No Specify: ģ If Yes, Give Year or Dates 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Artist 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be (17. Father's Name (First, Middle, Last) Taiffer Antionette မ Leroy Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Blackburn - Daughter 4338 Declaration Circle 21017 Belcamp, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. June 28, 2008 Baltimore, MD. 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility E.F. Lassahn Funeral Home P.A. Inter the disease, or complications that caused the death. Do not entring mod of lying, such as carriac or respin orly arrest, or heart failure. List only the cluse on each line. 21087 Approximate Interval Between Onset and Death CHARACTE Die to force mediate Cause (Final **Physician** SUNDRAME years disease or condition resulting in death) /Medical e to (or as a consequence of): Examiner Ischemic Cardiomyopathy years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 \(\sum \text{Yes} \) 2 \(\sum \text{VNo}\) the Hospital or Attending Physician: The I thin 24 hours after death. the Funeral Director: After this certificate ha 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 108 PC C 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303 lauro JUNE 27 2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) TOUSON MO 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Glow It Spark DHMH 17 Rev 1/2001

ORIGINAL

DM

	-	For State Registrar	State of Ma		Department of Certificate of			giene2 () Reg. No.	08	21886	
Physician		1. Decedent's Name (First, Middle, Last) Eileen Thelma Underw			rwood	2. Date of De					
/Medica Examine		4a. Facility Name (If not institution Catonsvil		-		or Location of Dear	h	4c. County Balt	imore		
Funeral Director		5. Social Security Number 214-20-5927	6. Sex 1 ☐ M 2 🕱 F	e (In yrs. last bir 81	thday) If Under 1 Yea Months Day		(Month, Day	y, Year) 1926		lace (State or Foreigr try) · land	
with the Maryland a or 28a-f show be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arundel	10c. City, Towr	or Location Linthic	cum			10	0d. Inside City Limits 1 □ Yes 2 No	
ath with the 23a or 28	al Director	10e. Street and Number	Midfield Ro	oad	10f. Zip Code	21090		10g. Citizen of V USA	Vhat Coun	try?	
after dez	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ied 1 □ Yes 2 🔯 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Control of Image of		Specify Yes or No- to Rican, etc.)		e - Americ ck, White, e	etc.	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Modical Exagnes.	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12) 12	t's Education st grade completed) College (1-4or 5	<u>5+)</u>	Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti .ndrews Air	re during most of wo red) Opera	ations	16b. Kind of Bu		•	
uld be filed Mental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle, nna Voge]		ne)		
and 2 sholesalth and 1 salth and 1 seath a		19a. Informant's Name/Relations Robert F. Under		4 \	. Mailing Address (Stre O4 Midfiel			-			
Pages 1 ament of He ant: If item ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	Glen H	f Disposition (Name of ry, crematory or other p Iaven Mem P		Date 0/08	20c. Location - Glen Bur	,	wn, State Maryland	
permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 21225-1856									
Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each li	d the death. Do ne.	Parla	lying, such as cardia				Approximate Interval Between Onset and Death	
The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence							
the death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/nths? 1 □ Yes 2 □ No 9 □ Unknown		of pregnancy 2 ☐ Fetal death at time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify,				ite of delive	ery Day Year	
quires that en signed build be deta	2	Part II. Other significant condition	ons contributing to death b		n the underlying cause	given in Part I.			tribute to th 3 ☐ Prob	ne cause of death?	
sician; The law re certificate has bee irector, page 2 sho	Completed						24a. Was autop perfo 1 □ Yes	rmed?	prior to cor death?	psy findings available mpletion of cause of 2 14 No	
cian; ertific ector,	Be (25. Was case referred to medica examiner?					ath (Check only o	ne)			
hysi this c	၉	1 Yes 2 No			Itpatient 3 1 DOA		Home 5 ☐ Resid	dence 6 □Oth	ner (Specif	ý)	
Jing F	Certification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investi 3 Suicide 6 Could	gation	ay, Year)	njury V M 1	njury at /ork? □Yes 2□No		now injury occur			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 ☐ Homicide determ	building, et	c." (Specify)	rm, street, factory, office		City or Tov	vn, State)		al Route Number,	
the Hos hin 24 hc the Fun npletely 1	Aedical	(Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis of and manner st	of examination ar	nd/or investigation, in m	y opinion, death oc	curred at the time,	date and place,	and due to	the cause(s)	
or viti	Σ	29b. Signature and title of certifie	~~ · · · · · · · · · · · · · · · · · ·	MA		P694		July Tuly	ea (Month,	Day, Year)	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. TURALUIA MD 1009, Frederick

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 29 **Physician** WINGATE DARLENE 1 · IOPM JUNE 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HARBOR HOSPITAL N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 F 53 215-66-2775 Director Maryland 17,1954 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 'natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21230 61 East Randall Street Pages 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23, and it item 27 is marked other, then "natural", or other traumatic event, the Medical Examiner musts any or other traumatic event, the Medical Examiner musts. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) McCormick Spice Co. Purchasing Coordinator Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Bennett Lydia Tolson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 61 East Randall Street, Baltimore, Maryland 21230 William M. Wingate (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 07-03-08 Bayview Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Pd-11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Precimonia <24 hour alcohol Aspiration /Medical Due to (or as a consequence of) Entoxication Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of) Examiner BEATON APPROVED BY MEDICAL that initiated events resulting in death) Last and The law requires that the death certificate be execu Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Unknown the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an performed? 1 Yes 2 □ I 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 5 Pending investigation Found 6/28/08 Found 11:45pm subject aspirated while intoxicated 1 ☐ Yes 2 No 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Lown, State)
61 E. Kandall St Baltunore (Ly) 28e. Place of injury - At hom building, etc. (Specify) 3 Suicide - At home, farm, street, factory, office determined 4 Homicide Home 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) realler RES 001 2008 JUNE 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANDVER STREET, BALTIMORE, MD - 21225 Nagamallika · Jash .

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32 Segistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05077 State of Maryland / Department of Health and Mental Hygiene 2008 21888 Frances Wood-Wright Certificate of Death 1- For State Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Month July 1, 2008 2304 hrs Physician/ FRANCES WOOD WRIGHT Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 702 N. Howard Street Apt. 2R 9. Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) If Linder 1 Year 7. Age (In yrs. last birthday) Social Security Number OCT.17, 1951 **Funeral** Davs Hours Months VIRGINIA 56 230-78-6201 1 M 2 F Yrs Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No BALTIMORE Baltimore, MD Z1z1z1zzzzzze
pemit. Pages I and 2 should be filed within 72 hours after death with the pump.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.
injury or other traumatic event, the Medical Examiner must be notified at once. 109. Citizen of What Country? USA 10e. Street and Number 10e. STREET APT. 2R 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Armed Forces? 1 Never Married 2 Married WHITE 2 X No Yes Specify: 1 Yes 2 XNo specify: 4 XDivorced If Yes, Give Year Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) DISABLED DISABLED 11 18.Mother's Name (First, Middle, Maiden Surname) more, MD 21215-003
Pages 1 and 2 should be filed within
nent of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) FRANCES RUTH GRIFFIN GEORGE EDWARD WOOD, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) REBECCA WOOD 182 N. CARROLL ST. ISLAMORADA FLORIDA 33036 sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition

1 Burial 2 K Cremation 3 Removal from State BAYVIEW CREMATORY BALTIMORE, MD 7/3/2008 4 Donation 5 Other Specify 22. Name and Address of Facility MCCULLY POLYNIAK FUNERAL HOME pa 21. Signature of Funeral Service Licensee 130 E. FORT AVE. BALTIMORE, MD 21230 ONAGO 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Physician failure. List only one cause on each line. Atherosclerotic cardiovascular disease **Tedical** Immediate Cause (Final disease aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): 7 events resulting in death) Last AMENDED 23a,2/,perME,g881 //25/08 TT and Physician/Medical e attending physician as for use as the burial - t X UNPENDED 23d. Date of delivery The law requires that the death certificate be 23c. If yes, outcome of pregnancy Box 68760, Year IF FEMALE: Day 3 Ectopic pregnancy 2 Fetal death 23b. Was decedent pregnant in the Live birth past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown Records, P.O. Completed by 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy page 2 should performed' 2 Yes 2 V No Yes certificate has 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Nursing Home 5 Residence 6 ✔ Other: Scene Division of Vital Be DOA examiner? Hospital: 1 ER/Outpatient 3 Inpatient 2 No 28d. Describe how injury occurred 1 Yes 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death Certification: 1 Yes 2 No 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 2, 2008 O.C.M.E.

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Amend 19a-b, perInf, G881 7/9/Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Whitaker Henderson 2008 7:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1705 N. Chapel Street

5. Social Security Number 5. Sex 7. Age N/ABaltimore
If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 3-22 Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Months Min. Hours 237-78-5246 Director 60 N.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Medical Exercities" is ust be retified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 □ No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 1705 N. Chapel Street Funeral U-S-A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes SyllyNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Black à Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade/completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) / A Elementary/Secondary (0-12) Hauler 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ David Whitaker Rowena Chavis 19a. Informant's Name/Relationship (Type. Print) **Tamara** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hill Road Balto, MD 21239 5757 Tamar Washington-Friend Mable 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Red 7-8-2008 Balto, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H 21202 1101 E. North Avenue Balto MD 2 arre 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Non-Small Cell luna marths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any learning to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1550 Orleans 57. CRBZ, ROOM 553, Baltimore, MD nvistinc 31. Date filed (Month, Day, Year) egistrar's Sign State JUL 08 Registrar

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/Medical

Examiner

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certificate

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To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 881 7-8-08 vt.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28,2008 Linwood Anthony Wise, Sr. TUNE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death N/A Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 M 2 □ F 217-68-2478 50 12,1957 Maryland Nov. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21211 USA 3511 Greenspring Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Truck Driver Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sadie Wisē Jesse Linwood Wise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvette Wise/Wife Greenspring Avenue Baltimore, Md 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2/08 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Catonsville, Maryland Western Star Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris FuneralHome 21. Signature of Funeral Service Licenses 5240 Reisterstown Road Baltimore, Md 21215 news 23a. Part1 Printer the discrese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sb. s, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) MMINES ACUTE MYOUNDED INFAMOTION Due to (or as a consequence of): 4 cms DISLUST CUNUNMY MARNY Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 4 LMS MOMIUSCUMUTIC CANDIUMS CHUM DISENSE Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 5MGG 4 SMWIDUSIS HYPER TENSIUN 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No PULMUNMMY 24a. Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home Statesidence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? P 27. Manner of Death Certification: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

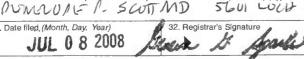
State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUL 0 8 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

5601 LOCK NOWN SUD BONDMUNG, MD

D15735

29d. Date signed (Month, Day, Year)

JULY 1, 2008

Shelby Delores Wilson State of Maryland / Department of Health and Mental Hygiene 2008 21891 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month July 4, 2008 1005 hrs Shelby Delores Wilson **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Towson 720 Boslev Avenue 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 212-86-5467 Months Dav Hours Director Country) MD July 21, 1967 40 1 M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Baltimore X Yes 2 No MD or items 23a or 28a-f show must be notified at once. imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, nent of Health and Mental Hygiene, in the Triem 27 is marked other than "natural", or items 23a or 28a-f shoon or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 780 N. Grantley Street 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Black Yes 2X No specify: f Yes, Give Year 3 Widowed Divorced 4 \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ file Clerk bank 11 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leroy Wilson Alemeta Andrews Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 780 N. Grantley Street; Baltimore, Maryland 21229 Annette Terrell / Aunt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/10/2008 Baltimore, Maryland Mount Zion Cemetery 4 Donation 5 Other Specify: Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street: Baltimore, Maryland 21217 PER DVR Albert P. Wylie 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Narcotic intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical 23a,PII,2/,28a-t perME, g881 //11/08 X UNPENDED X AMENDED signed by the attending physician be detached for use as the burial Iten#21.perFH.G881.7/9/08.WS Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Day 3 Ectopic pregnancy Month Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✔ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has death? performed? ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA After this 1 🗸 Yes ို 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: 1 Natural Funeral Director: / Yes 2 X No Pending FNd 7/4/2008Fnd 8:25 am unk 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) / 20 Bosley Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide (Specify) found in cell Cnty Det. Towson, MD (Balto. 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 5, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

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			1 - State of Maryla		artment of Health and Nartificate of Death		2008	21893	
			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death	
	Physic /Medi		Bernard Paul Zeitler			July	5 2008	9 1:43 p. M.	
	Exami		4a. Parility Name (If not institution, give street and number)	2	4b. City, Town, or Location of Death		4c. County of Death N/A	ı	
	Funeral Director		77	rs. la <i>st birthday,</i> 72 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Y July 13,	9. Birth Co. L935 Mary	nplace (State or Foreign Intry) Land	
	pur &		Usual Residence of Decedent 10a. State 10b. County 10c. (City, Town or L	ocation			10d. Inside City Limits	
	death with the Maryland me 23e or 28e-f show found be notified at	ច		shevill				1 ☐ Yes 2 XNo	
	28a-	Director	10e. Street and Number	SHEVILL	10f. Zip Code	10g	. Citizen of What Cou	untry?	
	3a or	0	115 Elm Drive		28805		JSA		
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White		
9	36 s after or its	by Fu	1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☐ No		1 XYes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,			
	hour hour		3 Widowed 4 Divorced Year or Dates: Unle		edent's Usual Occupation	16	Specify: Whi		
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	be tile	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	iden Sumame)		
•	rylg hould d Men marks marks	To	Bernard Zeitler Beatrice Huster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	Ma nd 2 sl ilth an 27 is r		Julie E. Zeitler/Wife		Elm Drive Aheville			p Code)	
	othe			. Place of Disp	osition (Name of imatory or other place)	Date 20	c. Location - City or T	own, State	
	Page Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		rematory, Inc 7/7/	08 Ba	altimore,	MD	
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examiner wint be notified at once.		21. Signature of Funeral Service Licensee C. Todd Dr	ing 2	2. Name and Address of Facility Cremation Society 199 Frederick Rd B	of Maryla	nd, Inc.		
	180		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest	MD 21220	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		dig/ Infa.			Onset and Death.	
	/Medical Examiner		resulting in death) Due to (or as a cons					, , , , , ,	
	191A	P.	Sequentially list conditions, if any, leading to immediate Due to (or as a cons	aquença of).					
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
V,	8760, sate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a cons	equence of):					
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	certifi ding	/Me	IF FEMALE: 23c. If yes, outcome of preg	gnancy			23d. Date of deliv	warv	
2 5	atte	Physician/Me	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of	etal death 3	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year	
7	transport	hys	9 Unknown						
00	Sign sign	à	Part II. Other significant conditions contributing to death but not r	esulting in the t	underlying cause given in Part f.		cco use contribute to		
	as been 2 should	pleted				24a. Was an	24b. Were au	topsy findings available ompletion of cause of	
2	The The ate has page	Comple				autopsy performe 1 ☐ Yes 2 €	death?	2 No	
7	VITAL I	Be (25. Was case referred to medical examiner?			th (Check only one)	· · · · ·		
. \	hys hys	ဥ		R/Outpatie				ity)	
	On ding I h. After funer	tlon	27. Manner of Death 1 Tatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred		
	DIVISION I or Attending after death. Director: Attending the fune	iflca	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, st			et and Number or Rui	ral Route Number,	
ä	Lalor Safte	Certification:	4 Homicide determined building, etc. (Spe	city)		City or Town,	State)		
	DIVISION C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	dlcal	29a. Certifier (Check only one) 1	nowledge, deat ination and/or ir	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the causered at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)	
	To th within To th compl	Me	29b. Signatury and title of certifier	0 /	29c. License number		. Date signed (Month		
	1	1	Jargine Bentus	m2	1 D63128	4	July 5	2008	
-			30. Tame and address of person who completed cause of death (It			0		D 2	
	Section 2		31. Date filled (Month, Day, Year) 22. Registrar's Sig	S CQ	ton Avenue	19911	more III	D 81229	
	Sta Registi	-	31. Date filed (Month, Day, Year) JUL 0 8 2008 Registrar's Sig	F Apo	ale)				

08-05102 Brian Zukowski Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 21894 Certificate of Death Reg. No. 1- For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day July 3, 2008 Physician/ 0828 hrs Brian B. Zukowski Mar & Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 408 North Haven Street If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year Foreign Country) 5. Social Security Number **Funeral** Hours Months 215-60-0653 7-4-1956 Director 1 X M 2 F 51 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 X Yes 2 No Baltimore City MD 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number Street Haven 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Was Decedent Ever in U.S. Funeral 11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married e, MD 21215-0036
I and 2 should be filed within 72 hours after death
Health and Mental Hygiene. 2 X No Specify: White Yes 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year Widowed 16b. Kind of Business/Industry ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) the Medical Computer Specialist Technolgy 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Viola Lisecki Bernard J. Zukowski Be ımafic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ို 4 Britmore Court, Baltimore, MD 21234 : If item 27 is nother traumatic Robin Wiseman - Sister 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, permit. Pages I and Department of Heal Important: If iten crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 7-7-08 Baltimore, MD Other Specify: Donation 5 22. Name and Address of Facility Bradley-Ashton Funeral Home ō 21. Signatura of Funeral Service/Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. 2 Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Narcotic (heroin) and alcohol intoxication 'ledical Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical X UNPENDED MENDED 7, 28a-f, perME, g881 7/10/08 TT 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Fetal death 23b. Was decedent pregnant in the Live birth attending or use as t past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 Unknown ğ σ. 24b. Were autopsy findings available 24a. Was an Completed of Vital Records, prior to completion of cause of director, page 2 should autopsy death? performed? certificate has b 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other: Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 DOA ER/Outpatient 3 this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After the 28a. Date of Injury (Month, Dey, Yeer) 27. Manner of Death 1 Yes 2 X No 1 Natural Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending Fnd 7/3/08 unk 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 108 N. Havem St Baltimore, MD 6 X Could not be 3 Suicide determined (Specify) vacant dwelling Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 3, 2008 O.C.M.E. 39. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 JUL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2008 21895								
			1. Decedent's Name (First, Middle, Last) Hilda Virginia Anderson		July 1, 26	998 Year 3. Time of Death 8:47pm м				
	Examir		4a. Facility Name (If not institution, give street and number) Glade Valley Nursing & Rehab Center	4b. City, Town, or Location of Death Walkersville	4	4c. County of Death Frederick				
ľ	Funeral Director		5. Social Security Number 220-10-5113 6. Sex 1 M 2X F 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Bay, Yea Jun 29, 1	9. Birthplace (State or Foreign Country) Mary Land				
Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	show	7	Usual Residence of Decedent 10a. State Maryland Frederick 10c. City, Town or Loc Walkers	ville		10d. Inside City Limits 1 X Yes 2 ☐ No				
	with the M a or 28a-f be notifi	Director	10e. Street and Number 56 West Frederick Street	10g. (Ditizen of What Country?					
	be filed within 72 hours after death with the Marylan hal Hygiene. od other then "natural", or Items 23a or 28a-f show svent, the Medical Exacitiver reast be recitived at	Completed by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 🕱 No	ras Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto □ Yes 2 🛛 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
	within 72 hou iene. then "naturally me Jick I		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse	alth Care						
	uld be filed fental Hygi rked other tic svent, I	To Be C	17. Father's Name (First, Middle, Last) John Walter Weaning	18. Mother's Nam Alta	o (First, Middle, Maid De li ah	^{en Sumame)} Keller				
	and 2 should be ealth and Mental n 27 is marked er treumatic sv		19a. Informant's Name/Relationship (Type, Print) Levona Crum, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10985 Horsehoe Dr, Frederick, Maryland 21701							
umore	Pages 1 nent of H ant: If iter ary or oth		'4 □Donation 5 □Other (Specify) Mt Olivet	Cemetery Jul 5,	2008 Fre	Location - City or Town, State ederick, Maryland				
Dait	permit. Departn Imports any inju		M00706 10	Name and Address of Facility Reeney & Basfo Do East Church St	reet, Fred	meral Home lerick, MD 21701 Approximate				
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each the. Immediate Cause (Final disease or condition resulting in death) Due to (or as a c hisacushice of):							
Ords, P.O. BOX or requires that the death certification	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							
	artificate ing phys e as the	a)	IF FEMALE:							
	death e atter d for u	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	23d. Date of delivery Month Day Year						
	quires that n signed b ıld be deta		Part II. Other significant conditions contributing to death but not resulting in the un	co use contribute to the cause of death?						
	as 2		<i>Q</i>		24a. Was an autopsy performed					
VII	Physicien: The ribis certificate har ral director, page	o Be (25. Was case referred to medical examiner? 1 Yes 2 No No No No No No No							
	ing Phys After this uneral di	-	1 Yes 20 No							
	To the Hospitel or Attending Phys within 24 hours atter death. To the Funeral Director: After this completely filled in by the funeral di	ertification;								
	ne Hospite 124 hours ne Funeral bletely fille	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the To the comp	Ž	29b. Signature and title of certifier	29c. License number	29d.1	Date signed (Month, Day, Year) Tuly 2 2008				
	3		O. Name and address of person who completed cause of death (Item 23a) (Type, 13a) Date filed (Month, Day, Year)	75 IANET.	AV FR	(J) MD 21762				
	Sta Registr		31 Date filed (Month, Day, Year) JUL 0 8 2008	<i>U</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008 21896 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician catherine 18:35 M 06 -16-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner montgomery General Hospital montgomeri 5. Social Security Number If Under 1 Year | Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 10-210-19 **Funeral** 577-60-5374 Days Months Hours 1 M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantiner must be notified at once. washington 1 Ves 2 No DC **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20011 First St NW 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 10 No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify: λq 3 Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) GOVERNMENT Elementary/Secondary (0-12) security DYOCESSINC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) maril aldine ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bolden Inephew 1949 autumn Ridge Circle Silverspring, mD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Arlington National Cem. 06/23/2008 Arlington; 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi 814 upsnur 3t NW Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Deer only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

rover Philip Dr

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 21897 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 29 6:30A June Blalock John Winston /Medical 4a. Facility Name (If not institution, give street and number) 4h. City Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) 9. Birthplace (Str. Country)
June 24, 1914 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 XM 2 ☐ F Months Days Hours 94 Director 579-07-2189 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Weder Exerciting that by Indiffed at 1 XX Yes 2 □ No Director Florida Volusia DeBary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Florence Blvd. 32713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: <u>ک</u> 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) engineering/ Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed wi th and Mental Hygier 7 Is marked other th 11 accountant development 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wiley Blalock Nettie Martelle Rice ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau Barbara Nunneley/ daughter 1345 Olde Doubloon Dr. Vero Beach, FL 32963 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/3/2008 Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) Fairmount Cemetery 21. Signature of Funeral Service Licen 22. Name and Address of Facility Hartzler Funeral Home Libertytown, MD 21762 11802 Liberty Rd. 23a. Part1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis (VRE) disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coagulopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Vancomycin resistant enterococcus bacteremia attending physician and for use as the burial-tran Physician/Medical Cardiac arrest IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Ö signed by the betach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by icate has been siç , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No Vital 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To of this After thi funeral o the Hospital or Attending Pl ithin 24 hours after death. o the Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6/29/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sima Noura-Feur 8600 Old Georgetown Rd. Bethesda, MD20814 . Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 8 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 William Brown 08:15 a^M Stewart June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F Months Director 578-66-0040 31, 1949 May Montelair, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, i'm, "a dical Experience august be nytiffed at Director 1 ☐Yes 2 XNo VA Fairfax Great Falls 10e. Street and Number 10g. Citizen of What Country? 11915 Holly Spring Drive 22066 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after (Hygiene. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 No ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Sr. Project Manager Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) þ Arlie Joseph Brown Audrey H. Perry ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health e Important: If item 27 is any Injury or other tra <u>Leta A. Brown / Wife</u> 11915 Holly Spring Dr., Great Falls, VA 22066 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 07/01/2008 Chestnut Grove Cem. Herndon, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 721 Elden St. Roleghe M. Male Adams-Green Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 20170 Herndon, VA Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final arteriosclero **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ng physician and as the burial-tran Due to (or as a consequence of) 68760 b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. 9 Funeral Director; After this certificate has been signed by the attending physician Be Completed by Physician/Medical signed by the attendir the detached for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify). 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☑No 24a. Was an 2 🗹 No 2 2 No the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records,

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filled in by

Registrar

DHMH 17 Rev 1/2001

may

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

wen

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Ma	iryland	•	artment of rtificate of				2008	2189	39
	Physicia	an	1. Decedent's Name (First, Middle,			D			2. Date of Dea		2 00 8	3. Time of Deat	h
	/Medic	al	Jane 4a. Facility Name (If not institution,	Sueann give street and number)		В	rooke 4b. City, Town,	or Location of Deat	June		County of Death	1120	101
Ì	Funeral Director		220-34-1303	6. Sex 7. Age	HOSP (In yrs. la: 72	TPL st birthday) Yrs.	HAGERS If Under 1 Yea Months Days	If Under 24 Hrs		h y, Yea <i>r)</i>	9. Birth Cour Mary	lace (State or For ntry)	eign
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Lin	nits
	e Mary 3a-f sh iificd	Director	MD All	egany			Cumberla	ınd				1 ☐ Yes 2 🔀	No
	th with th 23a or 24		10e. Street and Number 10229 Count	ry Club Roa	d		10f. Zip Code	21502		10g. Citiz	en of What Cour USA		
036	72 hours after death with the Maryland 'natural'', or items 23a or 28a-f show dical Examinat De Indiffied at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ N If Yes, Give Year or Dates:			Was Decedent of fYes, specify Cu 1 □Yes 2 1 No	Hispanic Origin? (sban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	1	4. Race - Americ Black, White, Specify:		
Maryland 21215-0036	ithin ne.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12	s Education grade completed) College (1-4or 5-	+)	(Give	dent's Usual Occ kind of work don DO NOT use retir Barte	e during most of wo ed)	rking		ntertai		
nd	oe filed w tal Hygie d other tl event, In	Be C	17. Father's Name (First, Middle, L					18. Mother's Na	me (First, Middle,	Maiden S	Surname)		
ryla	should be tand Mental s marked o	၉	Park 19a. Informant's Name/Relationsh	Emerson	B	eeghly		Ethel et and Number or A		lae ar City or		theraft 	
, Ma	and 2 sho ealth and n 27 Is ma		Harlan E. Brooke					ry Club F		-		21502	
Baltimore,	Pages 1 ament of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			berlai	sition (Name of natory or other pi nd Crema	tory 06/	Date / 20 / 2008	Cum	cation - City or To	, MD	
Balt	permit. Pages Department of Important: If It any Injury or once.	,	21. Signature of Funeral Services	icensee Adam	(22	2. Name and Add	ress of Facility Actur Stree	iams Fami	TA L	uneral	21502	à •
	Physician	2 0	23a. Part 1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that caused inly one cause on each lin	e.			ving, such as cardia			SCTRICAL	Approximate Interval Between Onset and Death A HOURS	
	/Medical Examiner		resulting in death)	Due to (or as a	,	,	OBSTRU	CTIVE PLU	MONAMY	Dist	ASE	IFARS	
	rted *	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a conseque	ence of):	TERY	DISEAS				YEARLS	
60,	icate be executed physician and the burial-transit		that initiated events resulting in death) Last	c. <u>CORON</u> Due to (or as a			,12101	DIZELIZ					
68760	g physi as the t	edical		d									
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3	Ectopic pregna Other (specify)			2	3d. Date of deliv Month	ery Day Year	
ds, P.	ires that the signed by the detaction of	þ	Part II. Other significant condition	ns contributing to death bu	it not result	ting in the u	nderlying cause g	iven in Part I.	1.00	obacco us		he cause of death	
Vital Records,	The faw require te has been si age 2 should I	Completed								rmed?	prior to co death?	ppsy findings avail mpletion of cause	
/Ital		Be C	25. Was case referred to medical examiner?						1 ☐ Yes ath (Check only o	ne)	1 🗆 Yes	2 🗆 140	
=	this lidi	၉	1.AYes 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Injur		R/Outpatier 28b. Time o	IL 3 LI DOA		Home 5 Resid			fy)	
ion	tending Phy Jeath. tor: After thi the funeral o	atior	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day ation		Injury	l W	ork? ⊒Yes 2 ☐ No	200, 000000				
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At hom :. (Specify)	ne, farm, str	eet, factory, office		28f. Location (5 City or Tov			al Route Number,	
	Hospi 24 hou Funer etely fil	edical		Physician: To the best of examiner: On the basis of and manner sta	examination								
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier					nse number	_	29d. Date	e signed (Month,	Day, Year)	
	2/1)	MD	-			6289	5 ;	Jun	2 19	2008	
	MAS		30. Name and address of person v	-	()	23a) (Type, Sed UQ	. /1	ve Hag	eistonen,	MD	2174	2,	
ı	Sta Registr		31. Date filed (Manth, Day Year)	32. Registra		_/\	(i)	, J					

		_	For State Registrar		Marylan		artment of H			Reg. No.	2008	
٠.	Physici		1. Decedent's Name (First, Middle Florence	e, Last) e B ra ndenbi	urg				2. Date of Deadler	ath 30 <mark>,</mark> Day	20 0 8	3. Time of Death 3:46p
)	/Medic Examin		4a. Facility Name (If not institution Frederick			.1	4b. City, Town, or Frede	Location of Death	1		County of Death	<u> </u>
8. [8]	Funeral Director		5. Social Security Number 215–14–2230	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da June 14	y, Year)	9. Birth Cou 8 Mary	place (State or Foreign ntry) 'land
	land t		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Mary a-f sho ified a	tor	Maryland Fre	derick		Burkit	tsville					1∏Yes 2□No
	or 28	Direc	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
	eath w	Funeral Director	202 Main Street		dent Ever in U	S 13 '	2171		pecify Yes or No	. 11	USA 4. Race - Ameri	can Indian.
336	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed For ned 1 ☐ Yes If Yes, Giv	rces? 2 X No		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2🂢 No	Specify:	o Rićan, etc.)		Black, White Specify: Wh:	etc.
15-0036	in 72 hou "natura ledical E	Completed	(Specify only highe	t's Education st grade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of world)	king	16b. Kin	d of Business/Ir	ndustry
212	d with giene. er thar	Comp	Elementary/Secondary (0-12)	College (1	-4or 5+)	Home	emaker			OWI	n Home	
Baltimore, Maryland 2121	eve eve	Be	17. Father's Name (First, Middle, Harvey Russell				:	18. Mother's Nam	ne (First, Middle, Magie W		Surname)	
يج	should and Men marke	ပ	19a. Informant's Name/Relations			19b. Mailii	ng Address (Street				Town, State, Zi	p Code)
Ĭ,	alth a		Virginia Axlin	e / daught			Woodland		Woodsbor	o, M	aryland	21798
ore	Pages 1 a nent of Hea int: If item iry or othe	- 6	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from S			nsition (Name of matory or other place		Date		ation - City or T	
Ħ	permit. Pag Department Important: I any Injury o once.		4 ☐ Donation 5 ☐ Other (S		Şt.		s Luthera 2. Name and Addre		-		n Stree	, Maryland
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	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a	5.5500	time		ng, such as cardiac				Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conseq	uence of):	~			-		
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):						
ار در	ficate be executed physician and is the burial-transit	Examiner	Cause (Disease of injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):						
68760,	cate be ohysicia the bu	edical		d								
O. Box 6	ath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□ Yes ♣ No 9□ Unknown		irth 2□Feta ant at time of c	aldeath 3[□Ectopic pregnancy □ Other (specify) _	y		23	3d. Date of deli	very Day Year
ο.	res that the de signed by the a be detached (Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
rds	w requires been sign should be	ed by	Chroni	ic Kid	nen	disa	ase		1 🗆	Yes 2□]No 3□ Pro	bably 4 Unknown
Vital Records,		Completed							24a. Was auto perfo 1□ Yes		24b. Were aut prior to death? 1 ☐ Yes	topsy findings available completion of cause of
Vita	Physician: The this certificate are director, pag	Be	25. Was case referred to medica examiner?	Unomitals			ot 2000 Oth	26. Place of Dea				
	Phys er this eral dir	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time o	IL SU DOA	4 LI Nursing H	lome 5 ☐ Resi 28d. Describe			ify)
ion	Attending F death. ctor: After y the funera	atior	Z L Accident	gation	th, Day Year)	Injury		1k? Yes 2∐No				
Division or	ire ire n b	Certification:	3 Suicide 6 Could 4 Homicide detern	ningd Zoe. Flace	of injury - At heng, etc. (Special	ome, farm, st	reet, factory, office		28f. Location (City or To		Number or Ru	ral Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (29a. Certifier (Check only one) 2 Medical	ng Physician: To the	asis of examina	owledge, deat ation and/or in	th occurred at the ti	me, date and place opinion, death occu	e, and due to the urred at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	ro the vithin 2 the comple	Med	29b. Signature and title of certific		ner stated.		29c. Licens	e number		29d. Date	e signed (Month	, Day, Year)
)	- > - 0		> Clevel	west,	sutr	2	mo	0057689	0	71	1/2005	8
	6		30. Name and address of person	e Gess	stm	s (e	Print) of th	Aven	ne Br	(NSW	N, Ysia	ND 31716
- First	Sta		31. Date filed (Month, Day, Year,		egistrar's Sign	ature	el i				,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** JUNE 1:30P M 29, 2008 **JAMES** LEE BLANK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year, Oct. 17, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 **T**M 2 □ F 72 Director 218-34-3718 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 217710 Marvland Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5624 Stone Road 21703 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evamina. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer/Stone Mason Construction 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William E. Blank, Jr. Ethel M. Young ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruth V. Blank, wife 5624 Stone Road, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rocky Springs Cemetery July 2, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee ²²Keeney and Basford PA Funeral Home Ric MOO255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Miknown Completed

Be

Certification: To

Medical

I or Attending Physician: after death.

the Hospital

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performe 26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Matural 5 ☐ Pending investigation

2 Accident

3 Suicide

4 ☐ Homicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 6 ☐ Could not be

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a, Certifier (Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

dariua, MA

20065443

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elena Iarikova, M.D., 400 West Seventh Street, Frederick, MD 21701 32. Registrar Signatu 32. Hegisian

State Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Physician Chumpitaz Virginia Huapaya 22, June 1559 /Medical 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 27 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Peru Oct. Director 579-21-3537 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ortant: If Nem 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Wedickl Evants and the motified at Md. Mont. Rockville X□Yes 2□No Director 10f. Zip Code 20851 10e. Street and Number 10g. Citizen of What Country? 13209 Ardennes Avenue Peru permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23s any injury or other traumatic event, trail was Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 M□Yes 2□No Specify: Peruvian Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Self-Employed Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marta Chumpitaz Nolberto Huapaya ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13209 Ardennis Avenue Rockville, Md. 20851 19a. Informant's Name/Relationship (Type. Print) Antonio Raul Rodriguez (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 30,2008 Peru 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, 3447 14th Street, N.W. W Inc. BACUNICC361 Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multi Organ Failure /Medical Due to (or as a consequence of) Examiner Renal Failure Sequentially list conditions Examine Due to for as a consequence of if any leading to immunicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Myocardial Infarction physician and s the burial-tran: Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Respiratory Failure 24a. Was an autopsy 2 XNo **2**√□No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064100 June 23, 2008 250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, M.D. 1500 Forest Glen Rd. Silver Spring, Md. 20917 Tate file 2 (Manth 2008 Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 20°08 Louise Culver Crouse July 8:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4445 Hope Acres Drive White Plains CHarles 8. Date of Birth (Month, Day, Year)
June 3,1928 N. Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2√2√5 Director 242-32-4802 80 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director 1 ☐ Yes ŽŽNo MD Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 1602 Thomas Road 20744 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 **N**0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 🗙 Yo Specify: þ Specify: 3€Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 rent of Health and Mental Hygiene.
nt: If item 27 is marked other than "n ry or other traumatic event, the Medi Elementary/Secondary (0-12) College (1-4or 5+) Librarian Public Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Walter Culver Ellen Elizabeth Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Kerth/Granddaughter 4445 Hope Acres Drive White Plains, MD20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or July 5 ☐ Other (Specify) 4 □Donation Metropolitan Cr. Alexandria, VA 3,2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond Funl. Service, P.A. M006415635 Washington Ave., La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** umonana /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760客 Due to (or as a consequence of): Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Alzheimen 1 ☐ Yes 2 X No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1∐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Granddaughter's Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 1 ☐ Yes 2 🗖 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Valural 5 ☐ Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide າ 24 hours af ne Funeral ເ Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier ca (Check only one) and manner stated. within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 office Road, waldorf. MD 20602 Suresh D M 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar JUL 0 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	State of	Marylan		artment of F rtificate of I		d Mental Hy		2000	21	0.01.
		Registrar 1. Decedent's Name (First, Middle, L	ast)				Death	2. Date of De	Reg. No.	ZUUO	3. Time	of Death
Physic	ian							Month	Day			30 aMn
/Medi		Margaret Louise 4a. Facility Name (If not institution, g		hor)		4b. City, Town, or	Location of D	June 13	-	County of Death	11.	. 30 am
Exami	ner			Jei)		Clinto		calli		ince geo	roe!	5
<i>y</i>	•	Pine View Nursin 5. Social Security Number 6.		. Age (In yrs.	last birthday)	If Under 1 Year	II If Under 24	Hrs. 8. Date of Bir		9. Birtho	ace (State	e or Foreign
Funeral Director		245-36-6515	1 □ M 2 🛣 F		33 Yrs.	Months Days	Hours N	Min. (Month, Da 9/28/19	y, Year) 24	Ashv	^{try)} ille.	N.C.
		Usual Residence of Decedent					ļ	7/20/22				
ylanc ylanc		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1		City Limits
Mar Mar	향	Maryland Prince	george's	Fore	estvill	e					1 x Ye	es 2□No
h the	Director	10e. Street and Number	BB	1202		10f. Zip Code			10g. Citiz	zen of What Coun	try?	
5-UUSO 72 hours after death with the Maryland natural", or items 23a or 28a-f show	a l	5223 Daventry Te	rrace			20747			Unit	ed State	S	
deal	Funeral	11. Marital Status	12. Was Deced Armed Force	ent Ever in U. es?	.S. 13.\	Was Decedent of H	ispanic Origin an. Mexican. P	? (Specify Yes or No werto Rican, etc.)	- 1	14. Race - Americ Black, White, e		
after or its	F	1 Never Married 2 Married		₩ No		1 □Yes 2√2 No	Specify:			Specify: Bla		
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d Z I Z I		17. Father's Name (First, Middle, Las	st)		Dome	Stic	18. Mother's	Name (First, Middle		vate Surname)		
Viana /	Be		5.7							,		
ITE, INIALYIATIO ZIZIO-UUJO SI and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, The Markeal Examiner must be notified as	မှ	Samuel Pitts 19a. Informant's Name/Relationship	(Time Print)		10h Mailir	on Address (Street		<u>Calbert</u> or Rural Route Numb	er City o	Town State Zin	Code)	
MICH d 2 sho th and 7 is ma trauma				_		•			-			07/7
e, IVI 1 and 2 Health em 27 i	-	Marion Burrows /	Daugnter			sition (Name of natory or other place		ce Foresty		eation - City or To		
Pages Thent of The service of the se		1 ☑ Burial 2 ☐ Cremation 3		ate	*		· i	01/0000	T . 1			
Dallillion permit. Pages Department of Important: If it any Injury or o		4 ☐ Donation 5 ☐ Other (Spec		на		nemorial Name and Addre		21/2008 Pope Fune:		lover, Ma		nd
Department on the property of		21. Signature out uneral service ac	ense		l l			rope rune: ke Forest		•		07/7
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		shock, or heart failure. List on Immediate Cause (Final			20	11	1.	n rapasis e			interval E Onset an	3etween 19 Death
Physician /Medical	ı	disease or condition resulting in death)	a	ona	m	ATICA	_on	THE			241	
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attending	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7			2	23d. Date of delive	ery	
death death a atte	cia	in the past 12 months? 1 □ Yes 2 ☑ No	4 🗆 Pregna	rth 2□Feta int at time of o		☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	·y			Month	Day	Year
oy the acher	Physician/Me	9 Unknown	9 Unkno	wn								
that ned I	by P	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco u	se contribute to the	e cause o	of death?
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/slcie	0 0	examiner? 1 ☐ Ye,s 2 ☑ No	Hospital:	patient 2 🗆	ER/Outpatier	nt 3 🗆 DOA Oth	or.	ng Home 5 ☐ Resi		Other (Specif	v)	
B Phy er this		27. Manner of Death	28a. Date of	Injury	28b. Time of			28d. Describe			,,	
After	텵	1 V Natural 5 ☐ Pending 2 ☐ Accident investigati		, Day, Year)	Injury		K? Yes 2 □ No					
Atter r dea	ifica	3 ☐ Suicide 6 ☐ Could not	28e. Place 0	f Injury - At he	ome, farm, str	eet, factory, office		28f. Location (Street and	d Number or Rura	l Route N	umber,
a affe	Certification:	4 Homicide	bullaing	g, etc. <i>(Sp</i> ecii	<i>(y)</i>			City or To	wn, State			
spita hours nera y fille	a	29a. Certifier 1 Certifying	Physician: To the b	est of my kno	owledge, deat	h occurred at the ti	me, date and p	place, and due to the	cause(s)	and manner as s	tated.	-(-)
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending in the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medical Ex	aminer: On the bas and manne		ation and/or in	vestigation, in my o	opinion, death	occurred at the time,	date and	place, and due to	tne caus	e(S)
To the within To the Comit	M	29b. Signature and title of certifier	1			29c. Licens				e signed (Month,)
1		1/1/	w			10-2	453	>	0	6,20,	08	
		30. Name and address of person wh	o completed cause	of death (Iter	m 23a) (Type,	Print)						
JC.		Laxmi N. Berwa M	1.D. 770	0 01d	Branch	Ave. Sui	te C-10	01 Clintor	ı, Ma	ryland 2	0735	
Str	ate	31. Date filed (Month, Day, Year)	32. Re	nistrar's Signa	ature							

Division of Vital Records, P.O. Box 68760, After Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

yas decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	Fetal death 3 Ectopic pregrime of death 5 Other (Specify)	ancy Month Day Year
Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 V Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26.Place of Death (Check	k only one)
examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpatient 3 DOA Other Nurs	ing Home 5 Residence 6 ✔ Other: Scene
27. Manner of Death 1 Natural 5 Pending 28a. Date of Injur (Month. Day Ye) Jun 15, 2008	y 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred Subject shot
Suicide Could not be	ury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 411 Zelma Avenue, Capitol Heights, Md.
29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examand manner stated.	knowledge, death occurred at the time, date and place, an ination and/or investigation, in my opinion, death occurred	ad due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
29b/Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

June 15, 2008

DHMH 17 Rev 1/2001 **OCME 2006**

Ö

State Registrar

DOME

Laron Locke MD.

Date filed (Month, Day, Year)

ame and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 16, 9:59 A M JUNE 2008 BESSIE Μ. CURBEAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan . 23, 1934 S. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔽 F 217-36-9453 74 Carolina Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examinating the hottlind at 1 Nes 2 No MD Prince Georges Laurel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8716 Chestnut Ridge Drive 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 XNo fYes, Give Baltimore, Maryland 21215-0036 1 ☐Yes 2 🙀 No Specify: Black Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Howard Co. I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Public Schools item 27 is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental tem 27 is marked o Pages 1 and 2 should be Pearl Lipton Samuel Agurs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Curbean, Jr (Son) 1515 7th St, Glenarden, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 🙀 Removal from State King Funeral Hm 6/20/08 Chester, SC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, Signature of Funeral Service Licensee 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear value. List only ne cause on each line. 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac Arrest /Medical Due to (or as a consequence of): Examiner End Stage Renal Disease Sequentially list conditions, if any including the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hypertension burial-tran and Due to (or as a consequence of): the attending physiciar Physician/Medical Diabetes Mellitus the as IF FEMALE: use yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ∐Yes 2 ∐**X**lo detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy certificate 1 ☐ Yes 2 🗙 No 1 ☐Yes 2 ☐No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1∐Yes 2MNo 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director; 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D019563 6/18/08 0

Registrar DHMH 17 Rev 1/2001

State

10

1500 Forest Glen Rd, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Purnimi Joshi, M.D.

23

2008

31. Date filed (Month, Day, Year)

JUN

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Grayson Baker Cochran June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington County

9. Birthplace (State or Foreign Country) Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Funeral Director 219-12-0108 84 March 5,1924 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examinational be notified at Maryland Washington County Boonsboro 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 1 amounts if item 27 is marked other than "natural", or items 23a or 1 amounts of the 1 amounts of the 1 amounts of the 1 amounts of 18408 Manor Church Rd. 21713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [∄Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: White ≦ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy M. Cochran Catherine T. Jones Cochran ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie M. Cochran-wife 18408 Manor Church Rd. Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Manor Church Cemetery 6-23-2008 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** PROBABLE ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician s the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an autopsy performed? 1 □ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 0058181 M.D 2000

SH3+1

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

31. Date filed (Month, Day, Year) JUN 2 5

KODUAH

324 E. ANTIETAM 32. Regierar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEPRATH

ST # 306 MAGTERS THUN MD 21740

State

Registrar

			For State of State of Registrar	Maryland /		rtment of H t <i>ificate of L</i>		lental Hyg ¤	jiene leg. No. 2	008	21908
*	Physicia		Decedent's Name (First, Middle, Last)	Lay	C	ook		2. Date of Dea Month JUNE	th 17, Day 20	08 ^{Year}	3. Time of Death 1030 M
	/Medic Examin	-	4a. Facility Name (If not institution, give street and num WMHS-Memorial Campus	ber)		4b. City, Town, or CUMBERI				nty of Death	1
	Funeral Director			7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02/10/1	, Year)	Cou	nplace (State or Foreign intry) ISYlvania
	show d at	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	eation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
:	nth the Mariant of a continue	Directo	PA Bedford 10e. Street and Number 132 Clay Court		Hync	10f. Zip Code	15545		10g. Citizen	of What Cou	untry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with frie Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the M-di-ai Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Was Dece Armed For 1 □ Never Married 2 M Married 1 1 Never Married 2 M Married	dent Ever in U.S. ces? 2 No 1942-	- !	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Amer Black, White	ican Indian,
2-003c	z nours ar atural", or al Exam	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv Year or Da	tes: 1946	la. Deced	Yes 2 1 No ent's Usual Occupa	Specify:	ina	Spe 16b. Kind o		White Industry
01717	giene. er than "n the M-di	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	4or 5+)	Tife. L	Servicema	n .			tail	
yland	ntal Hy ed oth ed oth	Be	17. Father's Name (<i>First, Middle, Last</i>) Walter Clay		Cook		18. Mother's Nam	,	Maiden Suri Ann	name)	Burns
	should nd Mei marke imatic	ည	19a. Informant's Name/Relationship (Type. Print)			g Address (Street a				wn, State, Z	
re, Ma	s 1 and 2 of Health a ltem 27 is other trai		Robert C. Cook, II / Son	20b. Place	of Dispos	Clay Coursition (Name of natory or other place	i	Box 481	Hyno 20c. Locatio		PA 15545 Town, State
Baltimore	nit. Page vartment or ortant: If injury or e.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services Licensee	State	erlan	d Cremat	ory 06/18	3/2008 ams Fami	Cumbe	erland neral	Home, P.A.
ň	imp imp any		Helle & adan	W		04 Decat				, MD	21502 Approximate
F	hysician		23a. Part Lenter the disease, or complications that control shock, or heart failure. List only one cause on example the cause (Final disease or condition resulting in death)	aused the death. Do ach line. iac Arrhy			g, such as cardiac	or respiratory ar	rest,		Interval Between Onset and Death
	/Medical Examiner	L	Cons	or as a consequence nary Arte or as a consequence	ery D	iscasc					13 years
	scuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	onary Fib	rosi	.s					5 years
8/00,	icate be executed physician and sthe burial-transit	edical Ex		or as a consequenc	e or):						
. Box c	death certif e attending id for use at	Physician/Med	23b. was decedent pregnant	come pf pregnancy irth 2 Fetal dea ant at time of death wn		Ectopic pregnancy Other (specify)			23d.	Date of del Month	ivery Day Year
дs, Р.	requires that the een signed by th nould be detache	by	Part II. Other significant conditions contributing to de Hyperlipidemia	ath but not resulting	g in the ur	nderlying cause giv	en în Part I.	23e. Did to			o the cause of death?
ပ	The law requate has been bage 2 shoul	Completed							rmed?	prior to death?	utopsy findings available completion of cause of
_		Be Co	25. Was case referred to medical				26. Place of Dea	1 Yes th (Check only o		1 ☐ Yes	2 □ No
_	Zir b	To B				t 3 DOA Oth	4 LI Nursing H	ome 5□Resid			cify)
Slon	ending Phy vath. or: After thi he funeral o	ation:	2 Accident investigation	th, Day Year)	o. Time of Injury	M 1□	yat k? Yes 2 □ No	28d. Describe I			
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	4 ☐ Homicide determined buildi	of injury - At home, ng, etc. (Specify)				City or Tov	vn, State)		ural Route Number,
	e Hospi 24 hou e Funer etely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the band maning and	best of my knowled asis of examination ner stated.	dge, deat and/or in	n occurred at the tir vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as ace, and due	s stated. e to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier		4 -	29c. Licens					th, Day, Year)
)	3+		30. Name and address of person who completed caus	e of death (Item 23)	a) (Type,	•	D0025296		JUNE	17,	2008
	NRS		Stephen P. Crossland	, MD, 200	Gl∈		t, Cumber	rland, M	ID 215	502	
	Sta Regist			egistrar's Signature		Ba)					

			1 - For State of Maryland / Dep Registrar State of Maryland / Dep	artment of Health and rtificate of Death	Mental Hygier	ne 2008 21909
	Physici	an	1. Decedent's Name (First, Middle, Last) Walter Ray Cubbage, Sr.		June 16,	3. Time of Death
	/Medio Examin	100	4a. Facility Name (If not institution, give street and number) 5116 Bay Parkway	4b. City, Town, or Location of Dea Huntingtown	th	4c. County of Death Calvert
*	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday, 90 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) Virginia
	e Maryland a-f show tifled at	ctor	10a. State 10b. County 10c. City, Town or Le	untingtown		10d. Inside City Limits 1
	with the	Director	10e. Street and Number	10f. Zip Code 20639	10g. (Citizen of What Country?
စ္	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	1 Never Married 2 Married 1 TyYes 2 No	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	iin 72 hours n "natural", Medical Exa	Completed by	3 X Widowed 4 □ Divorced Year or Dates: 1941-45	edent's Usual Occupation be kind of work done during most of wo DO NOT use retired)	orking 16b.	Specify: white . Kind of Business/Industry
212	ed with /giene er tha	Com	12 News	paper Supervisor		Newspaper
land	lid be filk lental Hy ked oth Ic event	To Be	17. Father's Name (First, Middle, Last) Henry Lee Cubbage	18. Mother's Na Ethel	me <i>(First, Middle, Maid</i> Elizabet	
Maryland	d 2 shouth and N 7 Is mai			ing Address (Street and Number or F 6 Bay Parkway, Hu		
altimore,	ages 1 an ent of Heal t: If Item 2 y or other		20a. Method of Disposition 100 Place of Disposition 20b. Place of Disposition cemetery, creation 2 Removal from State	osition (Name of ematory or other place)	Date 20c.	Location - City or Town, State
Baltir	permit. P Departme Importan any Injur		21. Signature of Funeral Service Licensee		ausch Funer	ral Home, P.A.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying, such as cardie	ac or respiratory arrest,	Approximate Interval Between Onset and Death
30x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	d	□Ectopic pregnancy		23d. Date of delivery Month Day Year
.0. Box	t the dea by the at ached fo	hysici	1 The past 12 Hollins? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Other (specify)		Monar Bay real
Records, P	equires tha en signed ould be det	کے	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
-	The lar	Completed			24a. Was an autopsy pertormed 1∐ Yes 2 / 2	
Viita	siclan certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	eath (Check only one) Home 5 Residence	a 6 ∏Other (Specify)
Division or	Attending Physician: The sr death. ector: After this certificate hat by the funeral director, page	ition: To	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 2 Accident Investigation		28d. Describe how in	
Divis	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.			
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number D 40370		Date signed (Month, Day, Year) June 18, 2008
gu)	8+1		30. Name and address of person who completed cause of death (Item 23a) (Type Peter L. Wisniewski, MD, 110 Hospi		ince Freder	ick, MD 20678
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 9 2008	4		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 For State Registrar/Amend#'s10e.19b.PerFHPCO6-26-08cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Month **Physician** Duvelsaint June 15 20:29PM Lovelt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1954 | Months | Days | Hours | Min. | (Month, Day, Year) | 1954 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F 53 September 20 Haiti Director 594-01-7679 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Prince Georges Hyattsville 1 ves 2 No Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 20783 USA 1706 Keyokee St. Keokee Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 🕱 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Custodian 6th d 2 should be filed with and Mental Hygier 7 Is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Duvelsaint Unknown Saintilia ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1706 **Exercise* St., Hyattsville, MD 20783 permit. Pages 1 and 2 sh.
Department of Health and Important: if Item 27 is ma 19a. Informant's Name/Relationship (Type. Print) Ermite Duvelsaint/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 21,2008 Washington, DC Mt. Olivet Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician We-9, /Medical Que to (or as a consequence of): Examiner patitis Sequentially list conditions, if my, in my laticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse uence of law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No l or Attend after death. Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and/manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of c ပ္ 2008 ess of person who completed cause of death (Item 23a) (Type, Print) Name 31. Date filed (Month, Day, Year) State 2008 Registrar

08-04743 James D. Douglas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21911

		- For State	Cert	tificate of	Death		Reg.	No.	
Physicia		Decedent's Name (First, Middle,Last)					2. Date of Death Month	Dav Year	3. Time of Death
ledical Examii			ouglas_				June 20, 20	08	0012 hrs
- may		4a. Facility Name (if not institution, give stree	t and number)	4	b. City, Town, or I			4c. County of Deat Prince George	
		Fort Washington Hospital	I =		Fort Washin		lo Data of Birth	(MM/DD/YYYY) 9. Bi	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ist birthday)	If Under 1 Year Months Days		_	Forei	nn I
Director		213-82-6875 1x M	₽_F	33 Yrs.			01/09/1	.975	Maryland
6		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Locati	00				10d. Inside City Limits
w any		,			011				1 X Yes 2 No
aryland 8a-f show at once.	후	MD Prince Geor	ges C1	inton	10f. Zip Code		100	, Citizen of What Cou	
Mar r 28a	Director	10e. Street and Number					109		,
ith the		6701 Springbrook Lar	1e Was Decedent Ever in U.	6 112 10/0	20735 s Decedent of His		necify Ves or No-	USA	rican Indian, Black,
ath w	Funeral		Armed Forces?	S. IS. Wa	es, specify Cuban	, Mexican, Puerto	Rican, etc.)	White, etc.	, section of the sect
er de:		3 Widowed 4 Divorced If Yes	Yes 2 X No		Yes 2 X No	specify:		Specify: p.1	ack
urs aft tural' iming	ğ	or Da 15. Decedent's Education (Specify only hig	es:	16a. Deceden	t's Usual Occupat	ion (Give kind of		16b. Kind of Business	
2 hou	Completed		ollege (1-4 or 5+)	during mo	ost of working life.	DO NOT use ret	ired)		
136 thin ther than	ם	12		Wareho	use Mana	ger		Federal G	overnment
5-0036 led within 72 hours after tygiene. other than "natural",	Ö	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	aiden Surname)	
21215-0036 buld be filed within ? Mental Hygiene. marked other than ic event, the Medical	Be	James Douglas					Marlowe I		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	မ	19a. Informant's Name/Relationship (Type, F	rint)	10	, , , , , , , , , , , , , , , , , , , ,			er, City or Town, Stat	e, Zip Code)
nore, MD 2121 ggs 1 and 2 should be fi nt of Health and Mental 1 it: If item 27 is marked other traumatic event,		Eric Jones / Parent 20a. Method of Disposition		6701	Springbr	ook Lan	é Clinto	on MD 20 20c. Location - City of	735
ore,		1 X Burial 2 Cremation 3 Re		crematory or oth		netery,	Date	200. Loodiion Oily L	, romi, oldio
Page nemt lant:		4 Donation 5 Other Specify:	Ft.	Linco	ln Cemet	ery 6/2	28/2008	<u>Brentwood</u>	, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Med		21 Signature of Funeral Service Licensee	1.40						Home, Inc.
	-	23a. Part II. Enter the disease, or complication	Maillan on the death	Do not enter th	01 Blade	nsburg F	Road Bre	ntwood, M	D 20722 Approximate Interval
Physician /Medical		failure. List only one cause on each line	э.	. Do not enter ti	ne mode or dying,	Suon as caraiae	or reopriatory arrow	,, 6.1.661, 6. 7.761	Between Onset and Death
Examiner			ple Injuries (or as a consequence of	f)·					-
		b	(or as a consequence of	.,.					
	ē		o (or as a consequence of	f):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	o (or as a consequence of	f):					
scuted and transit		events resulting in death) Last Due to	7 (01 20 2 0011004201100 0	-,-					
an ex	Medical	UNPENDED AM	ENDED						
760, icate be ex physician the burial	Med	IF FEMALE: 23	c. If yes, outcome of preg	nancy		-		23d. Date of delive	егу
x 687 h certific tending p	au/	23b. Was decedent pregnant in the past 12 months?	Live birth	_	etal death 3	Ectopic pregn	ancy	Month	Day Year
Box 68's death certification attending	siclan	1 Yes 2 No 9 Unknown 9	Pregnant at time of de	eath 5 Ot	ther (Specify)			1	79
O. B. trthe de by the	Phy	Part II. Other significant conditions conti	The state of the s	esulting in the I	underlying cause	given in Part I.	23e, Did tob	pacco use contribute t	to the cause of death?
ires that the signed by I be detach	þ		. 	y	, , ,		1 Yes	2 ✔ No 3 Pr	obably 4 Unknown
ords, w require s been signed be	Completed						24a. Was a		autopsy findings available
law re	휠	i					autops perforr		completion of cause of
tal Rec	흥						1 ✓ Yes 2	No 1 🗸	Yes 2 No
Vital Rec ysician: The l his certificate l	Be Be	25. Was case referred to medical examiner?	al: . To a contract to the con	1 55/0 1 11 1		Other Nurs		Residence 6 Oth	nor:
of Vital Records, ng Physician: The law require nfor this certificate has been si meral director, page 2 should b	욘	1 Yes 2 No	8a. Date of Injury	ER/Outpatient		ry at Work?		ow injury occurred	iet.
n of \ Iding Phy. h. After tl	ë.	1 Natural 5 Pending	(Month, Day Year) Jun 19, 2008	2334 hrs		Yes 2 ✓ No		uto collision	
ivision or Atten after death Director;	cati	2 Accident Investigation	28e. Place of Injury - At h	ome farm stre			28f. Location (S	treet and Number or	Rural Route Number, City
Division tal or Attendi s after death.	Certification:	Suicide 6 Could not be determined	(Specify) Major Roa			July State	or Town St	ate)	Fort Washington, MD
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Ö	29a. Certifier 1 Certifying Physician: T	o the best of my knowled	ge, death occu	rred at the time, d	ate and place, ar	d due to the cause	e(s) and manner as st	ated.
the Ithe Ithe Ithe Ithe Ithe Ithe Ithe I	edical	one) 2 Medical Examiner: On t	ne basis of examination a	nd/or investiga	ition, in my opinior	n, death occurred	at the time, date a	and place, and due to	the cause(s)
Tw. Wil	Mec	29b. Signature and title of certifier	manner stated.		29c. Licens	se number		29d. Date signed (A	fonth, Day, Year)
(17)		hy hi, ms	7		O.C.	M.E.		June 20, 2008	
Me		30. Name and address of person who compl	eted cause of death (Item						
20		Ling Li, MD Assistant Medic	al Examiner 111	Penn Stree	et, Baltimore,	MD 21201			
	ate	31. Date filed (Month, Day Year)	32. Registrar's Signat	ure					
Regis	trar	JUILW & TAND	de St Ca	AND STATE OF THE PARTY OF THE P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 19, **Physician** 2008 Nunzia De Gennaro 6:20 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Numbe If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, March 2, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1934 1 M 2 M F Days 107-30-8033 March Italy **Director** 74 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16306 Everwood Ct. 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes. Give Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be fili spartment of Health and Mental H portant: If Item 27 is marked ott y InJury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Be Paola Palumbo Nicoletta Piscitelli ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) De Gennaro / Spouse Matteo_ 16306 Everwood Ct. Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page: Department o Important: If i any injury or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/24/2008 Resurrection Cemetery Clinton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Death Immediate Cause (Final **Physician** 400 /Medical resulting in death) Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and ached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 2 N 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death b ut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ 🗐 3 Probably 4 Unknown Completed peen cate has I 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy certificate perform 1 □ Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩3 ↑□Inpatient ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Dear Certification: Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) T Natural 5 Pending investigation Injun after death Director: d in by the 1 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760 in 24 hours. the Funeral Directory filled in within 7 the

> W State Registra

29b. Signature at

30. Name and

DHMH 17 Rev 1/2001

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) 1200

Frederick Bruce I		- For State	St	ate of N	Maryla	nd / D	Departn Certific			and	Menta	al Hyg		Reg. No.	20	0 (8 219
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1		4a. Facility Name (i 795 Express		. 0	et and nui	mber)		4	lb. City, Too Owings			Death			County of D		ty
Funeral		5. Social Security N	Number	6. Sex		7. Age (Ir	n yrs. last b	irthday)	If Under		If Under		8. Date of E	irth(MM/	DD/YYYY) 9	. Birth	place (State or
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152207	o Be	John Ex			Print)		- 1	19h Mailine	Address	(Street		_	Troc	,	ity or Town,	State.	Zip Code)
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If titen 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	F	Laura R					1										
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Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical C	29a. Certifier		kaminer:On	the basis	of exami	knowledge, nation and/	death occu	urred at the ation, in my	time, da	ate and plant, death or	ace, and o	due to the o	ause(s) a ate and p	and manner a place, and du	is stat e to th	ed. e cause(s)
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State Registrar

Robert Schalger, M.D. Twin Beaches Medical Center North Beach MD 20714 31. Date filed (Month, Day, Year) 2 4 32. Registra s Signature 2008

30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** DeGrange 29 2008 5:30 Theda June Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Somerford Assisted Living Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 💢 F 1923 Virginia Director 21, 225-20-6142 84 Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 906 Marion St. 21740 Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 þ Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Sours Lottie Miller P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen DeGrange/Daughter 201 Gardendale Road, Terre Haute, IN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 7/2/2008 Smithsburg, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one c Immediate Cause (Final disease or condition Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consoverance of) Examine ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ breks 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: Surrsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 22 No 2 ER/Outpatient 3☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director, At completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due lo the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 Pennsylvana Tera 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 06/18/2008 ear Jesse Ray Dockery 16:40 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital/Transitional If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 TINT Date of Birth Social Security Number **Funeral** 12 M 2 ☐ F Months Days Hours 0370171938 70 413-52-8328 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 Tyes 2 No Director Calvert MD Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be U.S.A.

4. Race - American Indian,
Black, White, etc. 3125 Lyons Creek Road 20754 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 21 If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Self_Empolyeed 12 Carpenter 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) tem 27 is marked oth Be <u>Lucy A</u>da Walker Albert Prichard Dockery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Lizzio/Significant Other 3125 Lyons Creek Road, Dunkirk, MD 20754 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Gardens 06/21/2008 Dunkirk. MD 21. Sign twe of Funeral Service Censee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oņset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Marsonard ced lung concer 6 Marths /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknown by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1□ Yes Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Matural n 24 hours after death.

e Funeral Director: A
bletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2 and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 1)56024 June 18 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth L. Abbot 110 Hospital Road, Suite 110, Prince Frederick, MD 20678 JÜN 23 32. Registras Signature State 2008▶

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 8

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E	xamir	er	4a. Facility Name (If not institu Bradford Oa			Home		4b. City, Town, o	Location of Death			c. County o		eorge's
Fu	ineral		5. Social Security Number	6. Se	ex 7. Age	(In yrs. last birt)	hday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir				place (State or Foreign
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and 2	om 27 ther tr	1	Margaret L. 20a. Method of Disposition	Cai	rroll/Si	ster HC				, WV 2		6-96 Location - 0		own State
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Ø. 9	ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C.								I	
death certificate be executed	physician and s the burial-transit		resulting in death) Last	- 1	Due to (or as	a consequence o	of):							
ficate be ex	physic the b	edicai		•	d						·			
5	ටු ස		IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome			2.5				23d. Date	of deliv	ery
death	ed by the attendin detached for use	Physician/M	in the past 12 months? 1 Yes \$ \in No		4 Pregnant at	2 Fetal death time of death		Ectopic pregnancy Other (specify) _				Mon	ith	Day Year
at the	d by the	Phys	9 Unknown		9□ Unknown					20- 014				be accorded to the
The law requires that the	s been signed I should be det	þ	Part II. Other significant con-	AITIONS CO	ontributing to death b	ut not resulting in	tne und	derlying cause giv	en in Part I.				3 ☐ Prol	he cause of death? bably 4 Dunknown
v requires	shoul	letec								24a. Was	-		Vere auto	opsy findings available
F 8 .	2 CI	Completed								auto perf	psy orm <u>ed?</u>	, g	rior to co eath?	ompletion of cause of 2□ No
VII.	rtifical ctor, p	0	25. Was case referred to med	tical					26. Place of Dea	th (Check only	2 X ⅓ one)	40 ,		2010
Of VILA Physician:	his ce Idirec	To B	examiner?		Hospital: 1 ☐ Inpatie	nt 2 ER/Out	tpatient	3□ DOA Oth	er: Nursing Ho	ome 5 Res	idence	6 🗆 Othe	r (Speci	fy)
fing P	Alter t funera	lon:	27. Manner of Death 1 Natural 5 □ Per		28a. Date of Inju (Month, Da	ry Year) 28b. T	ime of njury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe	how in	jury occurre	ed	
lor Attending after death.	ctor: y the	ficat	3 ☐ Suicide 6 ☐ Co	estigation uld not be ermined	9 28e. Place of Inju	ury - At home, fai	rm, stre		163 2 100	28f. Location	(Street	and Numbe	er or Run	al Route Number,
el or	od in to	Certification;	4 Homicide	Billinied	building, et	c. (Specify)				City or To	wn, Sta	ife)		
Hospitel or Attending	To the Funerel Director: Atter this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medi	fying Ph	ysician: To the best	of my knowledge examination and	, death	occurred at the tile	ne, date and place,	, and due to the	cause	(s) and mar	nner as s	stated. to the cause(s)
the thin 2	mplet	Med	one) 29b. Signature and title of cer		and manner sta			29c. Licens						Day, Year)
Twith	¥ 8		1 1067	11	(amor_			D352				ine 3		
	.1		30. Name and address of per-	son who	completed cause of	eath (Item 23a) (Туре, Р						- /	
	1		William T.	Tanr	ner, M.D.	11701	Li	vingsto	n Rd.Ft	.Washi	ng	ton.	4D	
	Sta		31. Date filed (Month, Day, Y	ear)	2. Registra	ar's Signature	_		•		٠ - ح	,-		
	Registi	al	JUL 08	2000	fre fin	13. 18	25.48	5						

08-05012 Jason Lee Farley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21918

on zee raney		- For State Certificate of legistrar		Reg. No.	
Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day June 29, 2008	3. Time of Death 1120 hrs
edical Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Smithburg	4c.	County of Death
		Route 491 south of Richie Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.		DD/YYYY) 9. Birthplace (State or
Funeral Director		232-19-8276 1M 2F 29 Yrs	Months Days Hours Min.	2/28/197	Foreign
any	+	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat		0) 1	10d. Inside City Limits
		MD PRINCE GEORGE HYATTSVI	LLE		1 XXYes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 7778 EMERSON ROAD	10f. Zip Code 20784	10g. Citi	zen of What Country? USA
ath with the frems 23a	Funeral I	11. Marital Status 1 Never Married 2 Married Armed Forces? 13. Was Decedent Ever in U.S. 13. Was If Y	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
			Yes 2 X No specify:		Specify: WHITE
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Healint and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) TECHN	nt's Usual Occupation (Give kind of w nost of working life. DO NOT use retin NICAL ENGINEER	vork done 16b.	Kind of Business/Industry TECHNOLOGY FIRM
003 within grene.	d W O	17. Father's Name (First, Middle, Last)		(First, Middle, Maider	Surname)
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be C	RICK FARLEY	KARRI	EN McCLUNG	
ID 212 should be and Ment 7 is marl	To E	19a. Informant's Name/Relationship (Type, Print) RICK FARLEY/FATHER P.0	ng Address (Street and Number or F BOX 457, INWOOD	Rural Route Number, 0 , WV 25428	City or Town, State, Zip Code)
Baltimore, MD semit, Pages 1 and 2 sh Department of Health and Important: If item 27 is injury or other traumat	-	1 X Burial 2 Cremation 3 Removal from State crematory or o		v 1	Location - City or Town, State
Itim Paginthent Strant:		4 Donation 5 Other Specify:			HOME, P.O. BOX 821,
Ba perm Depa Impe		(challen Mason	327 W. KING ST., MAR	TINSBURG. WV	25402
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac of	or respiratory arrest, st	nock, or heart Approximate Interval Between Onset and Death
raminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuated			
scuted and transit	Exan	events resulting in death) Last Due to (or as a consequence or):			
ž s-i	Medical	d. UNPENDED AMENDED			
760, cate be physicia	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregr		23d. Date of delivery Month Day Year
Box 687 e death certific the attending ped for use as the	/sician/	past 12 months?	Fetal death 3 Ectopic pregr Other (Specify)	laricy	World Bay
Box e death the atte	Physi	1 Yes 2 No 9 Unknown g Unknown		23e Did tobaco	co use contribute to the cause of death?
, P.O. rres that the signed by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Farti.		✓ No 3 Probably 4 Unknown
ords, for we requires is been signated be	1 -			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
COF e law r e has b ge 2 sho	du			performed	i? death?
tal Recionant The Incentificate Inception	ပ္ပိ	25. Was case referred to medical	26.Place of Death (Chec	k only one)	
Vita hysteia this cer il direct	1 P	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient			idence 6 Other: Scene
Of ig P inera	Ιë			'	rcycle left roadway
Vision Atte	ii.	2 ✓ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		or Town State	et and Number or Rural Route Number, City
Di spital hours a meral J	Cert	4 Homicide determined (Specify) Major Road / Highw 29a. Certifier - Contificion Physician: To the best of my knowledge death of			of Richie Road, Smithburg, MD
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death ocone) 2 Medical Examiner: On the basis of examination and/or investigations.	igation, in my opinion, death occurred	d at the time, date and	place, and due to the cause(s)
To To Cont	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month, Day, Year)
		Mon Brasself, MD	O.C.M.E.	J	une 30, 2008
a		30. Nam- and address of person who completed cause of death (Item 23a)	1 Penn Street, Baltimore, M	D 21201	
		24 Paristrar's Signature	T T ETHT QUEEK, Dalumore, IVI		
Regi	State	111 0 0 2000 Fd			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 **Physician** 9:15 a^{M} Miriam Guyton Flynn June /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Westminster Carroll Carroll Hospice Dove House Date of Birth (Month, Day, Apr 16 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 1916 MD Apr Director 155-01-7079 Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a. State 10h County 28a-f show traumatic event, the Medical Evan line near the notified at Director 1 ☐ Yes 2 ☐ No Carroll Westminster MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 23a 21157 18 Hahn Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Specify: à 3 ➡Widowed 4 ☐ Divorced White "natural" Completed 6b. Kind of Business/Industry
Western MD College 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CC Schools 5+ Art Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Bowlus Edgar G. Guyton ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau once. 16737 Creamery Road Emmitsburg, MD 21727 Paula Lindsay/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 06/2472008 M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Westminster, MD Meadow Branch Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Prints Duneral Home and Chapel, P.A. 21. Signature of Fineral Service Lic 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ementin disease or condition resulting in death) /Medical 6/19/08-6/21/00 Due to (or as a consequence of): Examiner STrolle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) ed by the detached i nis certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 Probably 4 Junknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death.

The Funeral Director: Af pletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Street Westminster MD 31. Date filed (Month, Day, Year) State JUN 2 4 Registrar 2008

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JUNE 20, 2008 8:05 A M JOHN DAVID FORD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE QUEEN ANNE'S 510 CROUSE MILL RD. 8. Date of Birth (Month, Day, Year) OCTOBER 24, 1933 If Under 1 Year _ If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 XM 2 □ F MARYLAND 218-28-3742 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director MARYLAND QUEEN ANNE'S QUEEN ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 CROUSE MILL ROAD 21657 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. 2 3 ☐ Widowed 4 🛱 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 CARPENTER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VERNON FORD KATHRYN BENNETT ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau DAVID JUSTIN FORD/SON 716 WARREN DRIVE, ANNAPOLIS, MARYLAND 21403 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State JUNE 21 CHESAPEAKE CREMATION STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease shock, or heart failure. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic LEFTUPPER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Kashi 17 Atam Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Exami Recurrent Part OBSTRUCTIVE PNEMONITIES
Due to (or as a consequence of): Recurrent burial-tran and Box 68760 attending physician Physician/Medical the IF FEMALE: for use yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed peen 0 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 2 □No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 w 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) High Street, CHES testaun, Wed 21620 é TR. VOUN 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Ma	ryland /	Depa Cer	rtment of F	lealth an Death	d Ment	al Hygi	iene a. No. 2	008	21922
ĸ.			Decedent's Name (First, Middle, La	ast)					2. Da	ate of Deat	h		3. Time of Death
×	Physici /Medic		OSCAR F	G	ROVE					onth ILY	2 ^{Day}	2008	7:15A M
	Examin		4a. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, o	r Location of D	eath			inty of Death	
			FREDERICK MEM				FREDERI				FRE	EDERIC	
Eut-7	Funeral Director			Sex 7. Age 1 🔀 M 2 🗆 F	(In yrs. last t	Yrs.	Months Days	If Under 24 H	vin. (N	ate of Birth lo <i>nth, Day,</i> 5-1922	Year)	9. Birthp Cour	place (State or Foreign ntry) MD
	pui		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ration						10d. Inside City Limits
	Aaryla f sho ed at	ō	MD Frederi			derick							1 X Yes 2 □ No
	the N 28a-	Director	10e. Street and Number	Cic	1100	ICLICA	10f. Zip Code			10	0g. Citizen	of What Cour	ntry?
	3a or	Ö	410 Columbus Avenue				21701				USA		•
	death ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of H	ispanic Origin	? (Specify Y	es or No-	14. [Race - Americ	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 271s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:			Yes, specify Cuba ☐ Yes 2K No	Specify:	uerto Rican	, etc.)		Black, White, ^{ecify:} White	
9	2 hou atura cal E	ted	15. Decedent's E	ducation		a. Deced	ent's Usual Occup	ation		-7		of Business/In	
21215-0036	ithin 7, ne. han "n e Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+		life. L	kind of work done of NOT use retired	1)	_		6		
	iled w Hygie ther t	S	17. Father's Name (First, Middle, Las	*)	He	eavy E	Quiptment	18. Mother's		Middle A		struction	on
Maryland	should be tand Mental Is marked of umatic eve	o Be	George C. Grove	,					e E. Br		naiden ban	namej	
<u>F</u>	shoul nd M mari	간	19a. Informant's Name/Relationship	(Type. Print)	19	9b. Mailin	g Address (Street				City or To	wn, State, Zip	Code)
	1 and 2 Health a tem 27 is		Marilyn L. White	Daughtei	<u>.</u>	2503	Hemingway	Drive Fr	ederick	., MD 2	21702		
ž.	of Her		20a. Method of Disposition	75	20b. Place cemei	of Dispos	sition (Name of natory or other place	ce)	Date	· [20c. Location	on - City or To	own, State
Ĕ	Pages ment of I ant: If Its ury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Zion I		an Cemeter	,	5-2008	M	Middlet	own, Mar	ryland
Baltimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Lice		101176		Name and Address East Chu					A. F.H	
	= 5		23a. Partf. Enter the disease, or con shock, or heart failure. List only	nplications that caused t	he death. Do							and ZIA	Approximate Interval Between
	Physician	i	Immediate Cause (Final disease or condition	Star		psi	<					1	Onset and Death
	/Medical		resulting in death)	Due to (or as a		-						1	
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	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):							
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8760,	ficate be executed physician and sthe burial-transit	dical E		· d									
89	tificate g phy as the	ledic			•								
ŏ	th cert endin	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		ith 3□	Ectopic pregnancy	,			23d.	Date of delive	
о Е	ne dea the att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at t 9□Unknown			Other (specify)					Month	Day Year
۳.	that the ed by detac	Ph	Part II. Other significant conditions	contributing to death but	not resulting	in the un	derlying cause giv	en in Part I.	2	3e. Did tob	acco use o	contribute to t	he cause of death?
Division or Vital Records, P.O. Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Completed by	Chronic Kidne	Discuse	, Stac	je 4				1 □ Y∈	es 2∏N	lo 3∏ Prot	bably 4 Unknown
000	faw re as bee 2 sho	plet	CAD						2	4a. Was ar autops		4b. Were auto	opsy findings available impletion of cause of
ř	siclan: The law s certificate has b lirector, page 2 s	No.	UTI						_	perforn	ned? No	death?	2□ No
Ita	clan: ertific octor,	Be (25. Was case referred to medical examiner?					26. Place of	Death (Che				
7	hysion this on al dire	일	1 Yes 2 No	Hospital: 1 Inpatien			t 3□ DOA Oth	4 L Nursin				Other (Specia	fy)
Ä	tending Physiclan: The leath. tor: After this certificate he the funeral director, page	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		. Time of Injury	28c. Injur Wor M 1 1	yat k? Yes 2∐No	28d. D	escribe ha	w injury oc	curred	
S	death death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined.	De 280 Place of injur	y - At home,	farm, stre		Tes 2[]110	28f. Lo	ocation (St.	reet and Ni	umber or Rur	al Route Number,
2	after after Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)					ity or Town			2
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.		29a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of o	my knowled	lge, death	occurred at the til	me, date and p	place, and d	ue to the ca	ause(s) and	d manner as s	stated.
	the Hi in 24 the Fi	Medical	one)	and manner stat	ed.	and/or in			occurred at	tne time, a	ate and pia	and due t	o the cause(s)
	Voit To	Σ	29b. Signature and title of certifier				29c. Licens		00	25	9d. Date si	gned (Month,	Day, Year)
			* July MD					00634	78		7/	2/08	
	Arl		30. Name and address of person who lakhvinder	completed cause of dea	,		r _{rint)} h Street F	rederick	Maryla	nd 217	01		
	Sta Registr		31. Date filed (Month, Day, Year)	82. Registrar		Soul							
			4 4 60 A A	A THE CASE OF THE	1	ALC: UNKNOWN							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 8:15 A 2008 Brenda Grammar June 14, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery Holy Cross Hospital 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 👿 F Director 8/9/1944 DC 63 <u>577-58-3452</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State iral", or items 23a or 28a-f show Examiner must be notified at Yes 2 No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 1110 Downs Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Energy Labor Relations Specialist 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Wimes Inez Pope 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 1110 Downs Drive Silver Spring, MD James Grammar/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 6/25/2008 4 Donation 5 Dother (Specify) Brentwood, MD yneral Service Licensee 22. Name and Address of FacilityMarshall's Funeral Home 21. Signature of 4217 9th Street, NW Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Massive Pulmonary Embolism /Medical Due to (or as a consequence of): Examiner Brain Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed Breast and Lung Cancer burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical for use as the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 📉 No Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy perform 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No **X**Inpatient 2 ER/Outpatient 3 DOA ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident frer death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

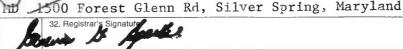
To the Hospital within 24 hours Registrar

30. Name and address of per n who co Purnima Joshi, State

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JUN 2 5 2008



death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

amend line 30 per phyPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 06/20/08 dlwState of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 June 0530 Yolanda Goodrum /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Au 3 8 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, **Funeral** Days Hours Min. Maryland 1 □ M 2 ☑ F 55 Yrs 212-60-0026 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be natified at 11 Yes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1800 D Copeland St. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Specialist Clerk Verizon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adell Lee Goodrum Mazie Quick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Curline Addison(Sister) 7632 W B A Road Severn, Md. 21144 20c. Location - City or Town, State 20a. Method of Disposition 20b. Hace of Disposition (Name of Vermolery Grematory by other place) 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens | 6-24-08 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) M.Mame Road Good Son Sons Mortuary, D.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 MO0483 D Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed Due to forms a consequence of) physician a the burial-t Box 68760. Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2 No signed by the a o 9 Unknown 9 I Haknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 □ Yes 3 □ No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2□No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 □Yes 2 □No within 24 hours after death

To the Funeral Director: A completely filled in by the f 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 21401 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) JOSEPH-HERBERT. MD. FARES. 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) June 19, 2008 **Physician** Jose Ernesto Guevara 2:07 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring, Md. Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Months 1 M 2 □ F 67 Yrs El Salvador 579-27-3412 11/13/1940 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 XYes 2 No Md. Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number El Salvador 20910 8708 Sundale Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 S Never Married 2 Married Specify: Salvadoran White 1X Yes 2 No Yes. Give p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Magdalena Rivas Leonidas Guevara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8708 Sundale Drive Silver Spring, Md. 20910 19a. Informant's Name/Relationship (Type. Print) 8708 Sundale Drive (Daughter) Rosa Chavez 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery + 06-27-08 Salvador 22. Name and Address of Facility W3447 Bacon Funeral Home, 21. Signature of Funeral Service Licensee Inc. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arthrosclerotic Cardiovascular Disease disease or condition resulting in death) Due to (or as a consequence of): Acute Coronary Syndrome Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Myocardial Infarction Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Physician /Medical **Examiner**

with the Maryland

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "Moleal Examinat is ust be notified at

Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23

altimore, Maryland 21215-0036

ng physician and as the burial-transit signed by the attending I cate has been signated by page 2 should b this certificate To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Completed by Be

25. Was case referred to medical examiner?

٩ Certification:

Medical

24a. Was an autopsy performe

1 ☐ Yes 2 🗓 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? М

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

5 ☐ Pending investigation

29c. License number H59837

29d. Date signed (Month, Day, Year) June 20, 2008

30. Name and address of person wito completed cause of death (Item 23a) (Type, Print)
Khanh Q. Nguyen, M.D. 1500 Forest Glen Road Silver Spring, Md. 20910

31. Date filed (Month, Day, Year) State Registrar

1 XYes 2 □ No

27. Manner of Death

1 XNatural

2 Accident

4 Homicide

3 ☐ Suicide

29a, Certifier

32. Registrar's Sign

and manner stated.

To the within 2

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:00 A M 2008 18, Lawrence E. Griffith June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Community Hospital Prince George's Cheverly Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1⊠M 2□ F 247-24-2592 Greer, SC Director 16, 1921 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modell Examination is notified at 1X Yes 2 No Director N/A DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 20012 U.S. 1207 Addison Road #301 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐ No
If Yes, Give
Year or Dates: unknown 1 Never Married 2 Married African 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No à 3 ₩ Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Unknown 12 should be filed with and Mental Hygier 7 is marked other the 10 Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Neely ၉ Forman Griffith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 st of Health ar if item 27 is or other tre 1405 Primrose Rd., N.W. Washington, D.C. 20012 Stephanie Gregg / Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 nent of H Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/21/2008 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD Maryland Nat. Cem 22. Name and Address of Facility McGuire Funeral Service, Inc. Undre 7400 Georgia Ave., N.W. Washington, D.C. 20012 hompso 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 HRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BOWEL OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical or Attending Physician: The law requires that the death certificate the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Dav in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>م</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig 9 JUNE 18, 2008 MI 8+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

PRINCE

32 Registrar's Signature

GREENMD

2008

LINDA D

31. Date filed (Month, Day, Year)

23

GEORGE'S HOSPITAL, CHEVERLY, MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** James A. Green /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hyattsville
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Prince George's Heartland Nursing Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 90 Yrs. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Months Days 579-12-3623 1 XM 2 ☐ F Director Virginia March Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f show notified at 1 Yes 2 □ No Director D.C. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 'natural", or items 23a or dical Examiner must be 5720 3rd Place, N. W. 20011 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any Injury or other traumatic event, the Medical Examine 1 TXYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 No Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk Federal Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Brown Roger Lee Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary C. Green /Wife 5720 3rd Place, NW, Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Monation 5 ☐ Other (Specify) Howard University 6/18/08 Washington, DC 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funo Service Licensee Bozi 14th Street, N.W.,

23a. Fart 1. Street, New 2.

Bozi 14th Street, N.W.,

Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line.

Immediate Cose (Final disease or indition resulting in death)

a.

Due to (or as a concernment) 3821 14th Street, N.W., Washington, DC 20011 **Physician** /Medical Due to (or as a consequence of): Examiner noumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or,as a consequence of) discusseller discusse Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐Yes 2☑No 5 ☐ Other (specify) 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à docubetus aeral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe Coummonne 25. Was case referred to dical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗗 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed physician and s the burial-trans Records, Division or Vital Hospital or Attending Physician: 24 hours after death e Funeral Director:

within 24

with the Maryland

Maryland 21215-0036

Baltimore,

State

Medical

29a. Certifier

May

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

and manner stated.

4701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kandoph

29c. License number

47867

29d. Date signed (Month, Day, Year)

Rd # ZIL ROCKALL MD 20852.

08-04635 Ronnie Lee Gibson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 21929

Office Ecc Oiboo		- For State	Oldic 0	i iviai yiai ie		ficate of D	eath		Reg	. No.	200	0 2	126
Physician	_	egistrar 1. Decedent's Name (First, Middle,Last)						2. Date of Death Month	Day `	Year	3. Time of Dea	
al Examinا الم		Ron	nie	Lee	G	650	0		June 15, 20	80		1645 hrs	
	4	4a. Facility Name (if r	-	street and number	er)		City, Town, or l lenderson	ocation of Death		Caroli	ity of Death		
		16840 Hende		17	Age (In yrs. last		f Under 1 Year	If Under 24Hrs.	8. Date of Birth			hplace (State of	or
Funeral Director	زا	5. Social Security Nu			Age (In yrs. last	, F	Months Days		_			n Mary	land
/ Director	4)	216-64-6		1 2 F	50	Yrs.			reb, a	5,115	01		
any		Usual Residence of D 10a. State 10	Ob. County		10c. City, To	own or Location						10d. Inside C	
À .,,		MD	Tallo	st	0	Lordo	Va					1 Yes	2 No
Maryland 28a-f show d at once.	Director	10e. Street and Num					0f. Zip Code		10	g. Citizen of	What Cou	ntry?	
the Maryland 23a or 28a-f sho		1164:	2 - Car	dova	Roc	ad	216	25		Z	15A		
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	<u>a</u>	11. Marital Status		12. Was Decede	ent Ever in U.S.	. 13. Was E	ecedent of His	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Amer	can Indian, Bla	eck,
death death	Funeral	1 Never Married		1 V Yes	2 No		45		, , ,	Spec	# 1R 1	ack	-
s after ral",	<u>~</u>	3 Widowed 15. Decedent's Edu		f Yes, Give Yeer or Dates:		(4)	es 2 No	specify: ion (Give kind of v	work done	16b. Kind o	1-42-1		
hour "natu	te -	Elementary/Secon		College (1-4	,	during most	of working life.	DO NOT use reti	red)				.
36 hin 72 than than	휌	12,				Car	retak	er		Esta	te Mo	NageM	ent
5-0036 led within 72 hours after Hygiene. I other than "natural", the Medical Examine	Completed	17. Father's Name (F	irst, Middle, Last)			,		18. Mother's Name	First, Middle, M	laiden Surna	ame)	•	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than ic event, the Median	8	Ben 19a. Informant's Nam	Jamir	Lee	Gi	bson	111111111111111111111111111111111111111	E/Va	Virgi	nia	Town State	Kins	
e, MD 21215-0036 I and 2 should be filed within 72 Health and Mental Hygiene. Filem 27 is marked other than " r traumatic event, the Medical	₽[from .		11 D	2/6/	1/
e, MD 2 l and 2 shou Health and IN item 27 is n	-	20a. Method of Disp	aine	Carte	20b. Pl	ace of Disposition	on (Name of cer	e AVE,	Date	20c. Locat	ion - City o	Town, State	
5 S S S S		1 Burial 2		Removal from					27/10	1111	clar	K M	$D \mid$
Baltimo permit. Pag Department Important: injury or of	1	4 Donation 5 21. Signature of Fun	Other Specify:	ee /	Ver	Terans 22. Nai	ne and Address	ery 6/	21/00	774	100	741.	<i>D</i> :
Balti permit. Departu Import injury	- î	Q-AMO	000-0	Don	w	HEI	VR4 FU	ineral	Home, I	amb	ri do	e MD.	21613
Physician	7	23 Part I. Enter the	disease, or compli	cations that caus	s the death. I	Do not enter the	mode of dying,	such as car lac	or respiratory arre	est, shock, o	r heart	Approxima Between 0	te Interval
Medical		failure. List only Immediate Cause (F	one cause on eac inal disease a. (m iine. Bunshot Woi	und of Ches	st						De	ath
xaminer		or condition resulting	-	oue to (or as a co									
	2	Sequentially list con		Due to (or as a co	onsequence of)):						+ -	
	Examiner	cause. Enter Under (Disease or injury th	lying Cause										
igi ge	Xar	events resulting in o	leath) Last L	Oue to (or as a co	onsequence of)):							
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60, ate be e ohysicia ne buria	Medical	IF FEMALE:			itcome of pregn	ancv				23d. Da	ate of delive	ry	
1876 Tiffical Ing ph		23b. Was decedent past 12 months		1 Live birt	th	2 Feta	l death 3	Ectopic pregr	nancy	Mor	nth	Day	Year
ox 6 ath cer attend	/sician/	1 Yes 2 N			nt at time of dea	ath 5 Othe	er (Specify)						
. BC	Phy	Part II. Other signif	_	g Unknow		sulting in the un	derlying cause	given in Part I.	23e. Did to	obacco use	contribute t	o the cause of	death?
P.O s that I	ð	, are in o this origina				•			1Yes	s 2 🗸 No	3 Pr	obably 4	Unknown
ds, equire	Completed		· · · · · · · · · · · · · · · · · · ·						24a. Was		24b. Were	autopsy finding completion of	s available
COF law rath has be 2 sho	헬	i								rmed?	death?		No
Re : The ificate		25. Was case refer	red to medical				26.Plac	ce of Death (Chec		2 110	· 💟		
fital sician is cert lirecto	o Be	examiner?	F	lospital: 1 In	patient 2	ER/Outpatient	3 DOA	Other Nurs	sing Home 5	Residence	6 🗸 Oth	er: Scene	
Division of Vital Records, P.O. Box 68760, To the Hospital or after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	-	27. Manner of Deat		28a. Date o	f Injury	28b. Time of In	· 1	ury at Work?	28d. Describe Subject sho		occurred		
on endin	itior	1 Natural 2 Accident	5 Pending Investigation	Jun 15, 2	008 007	1635 hrs	1	Yes 2 V No	13.50			v	
ivisior I or Attend after death. Director:	ifica	2 Accident 3 Suicide	6 Could not	28e Place	of Injury - At ho	ome, farm, street	, factory, office	building, etc.	or Town.	State)		Rural Route Nu	umber, City
Di e Hospital 124 hours a e Funeral J etely filled	Certification:	4 V Homicide	determine	(0)-057	Mobile Hor				16840 Hende				
n 24 h	cal	29a. Certifier (Check only one)	Certifying Physici Medical Examiner	an: To the best	of my knowledg	ge, death occurr nd/or investigati	ed at the time, on, in my opinion	date and place, a on, death occurred	nd due to the cau d at the time, date	se(s) and m and place,	anner as si and due to	the cause(s)	
To the within To the comple	Medical	29b. Signature and		and manner sta	ated.			nse number	- 1			Month, Day,Yea	ar)
N	2	230, Signature and	A STOCKING	11/15	1			C.M.E.		June 2	16, 2008		
0		30. Name and addr	n san	completed cause	of death (Item	23a)	AV dec			1			
×\	3	30. Name and addr Melissa Bra		ssistant Med			enn Street,	Baltimore, M	D 21201				
	ate	01 - 1 61 1 01		32	gistrar's Signatu		de	-					
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		-	For State			ryland	/ Depa		t of H	ealth a		ental Hy			8	219	30
			Registrar					Tuncau	9 OI L	Jeani		2. Date of De	Reg. No.			3. Time of	Death
10	Physicia	_	Decedent's Name (First, Middle T									Month	Day	2008	Year		A ^M
ш	/Medic	_	Verna	Pauline		Gowar	15	T 45 Cib.	Tours or	Location	of Dooth	June		County	of Death	6:55	A
	Examin	_	4a. Facility Name (If not institution			1			0ak1	Location o	oi Death		10.	_ ′	rett		
		-	Garrett County 5. Social Security Number	Memorial 6. Sex		pitai e (In yrs. las	t hirthday	1	1 Year		24 Hrs. 8	B. Date of Bi	rth		9. Birth	place (State o	r Foreign
	Funeral Director		234-56-5163	1 □ M 2 X F		7.5	Yrs.	Months	Days	Hours	Min	(Month, D	av. Yea <i>r</i>)	33	Cou	yland	
		-	Usual Residence of Decedent		1 .												
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		10a. State 10b. County 10c. City, Town or Location								10d. Inside Ci 1 ☐ Yes	-					
		혅	MD Ga	rrett				Accident					Citizen of What Cou			ZMINO	
		Funeral Director	10e. Street and Number					10f. Zip	10f. Zip Code				10g. Cit	izen of V			
		<u>=</u>	107 Old Engle							215				14 Poor	USA	ican Indian,	
		nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?				13.	 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 					0-		k, White		
36	s afte	by F	1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes. 0	∕es 2 X No s, Give or Dates:			1 ☐ Yes 2 【X No Specify:						Specify: White			
21215-0036	houn tural	Completed b							16b. K	16b. Kind of Business/Industry							
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112	with iene. thar		Elementary/Secondary (0-12)	College	(1-4or 5	(+)		Co	ok				R	esta	uran	t	
p	othe rent,	BeC	17. Father's Name (First, Middle,	Last)		_				18. Mothe	er's Name	(First, Middl	e, Maiden				
<u>a</u>	Aenta Aenta rked tic ev	To B	Frederick		Hı	ughes					anda	Mae			eman		
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n traumatic event, the Medi		19a. Informant's Name/Relations					_				Route Num					
	and 2 n 27 i		Roberta Stewart	/ Daughte	er	100						lent,	_			520 Town, State	
ore	iges 1 and 2 it of Health a if Item 27 is or other tra		20a. Method of Disposition 1 M Burial 2 □ Cremation	3 □Removal fro	m State			osition (Na ematory or					200. L		-		_
E	Pag ment tant:		4 □ Donation 5 □ Other (Lauı		ill C								Mary1	and
Baltimore,	permit. Pages 'Department of H Important: If Ite any Injury or of once.		21. Signature of Funeral Service	lem			S	tewar	t Fu	nera]	L Home	9 0a	S. klan			1550	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Issues or condition) Cerebrovascular Accident Approximate Interval Between Onset and Death 2 Years											Death			
			Due to (or as a consequence of): Ischemic Vascular Disease Years														
		Examiner															
,092	eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last	C	to (or as	a conseque	ence of):										
687	cate b	dical															
Вох 6	h certificate ending phys	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o		pf pregnan		□Ectopic	oregnand	У					ate of del	ivery Day	Year
P.O. B	0 0	Physician/Medi	in the past 12 months? 1 □ Yes 2 2 N o 9 □ Unknown	4□Pre 9□Un	egnant a	t time of dea	ath 5	Other (s	specify) _								
	The law requires that the de te has been signed by the age 2 should be detached	þ	Acute Penal Failure									ibute to the cause of death? 3 ☐ Probably 4X Unknown					
Š	v requ	etec			_							24a. W	as an	24b.	Were at	utopsy findings	s available
Division or Vital Records,	The lay ate has page 2	Completed	autopsy prioring d? autopsy performed? 1								death?	completion of 2 □ No	cause of				
/ita	cian: ertific	Be (25. Was case referred to medic examiner?	Lines Heli					Ot	hor		(Check onl					
7	ng Phy fter this ineral d	2	1 ☐ Yes 2 ☒ No														
n		ion:	1 Matural 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No No time of the control of t								,,,,,,						
Sign	ttend death stor: / the f	icat									ural Route Nu	mber,					
Div	al or A safter al Direction by	ertif	4 Homicide determined building, etc. (Specify) City or Town, State)														
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)												e(s)		
	To the To the To the Comple	29b. Signature and title of certifier 29c. License number					r	29d. Date s			ed (Month, Day, Year)						
	- 7-0) / X/	-					D23	979				6/	29/	08	
		4	30. Name and address of person						t.,	0akla	and, l	Maryla	nd	2155	0		
	St Regist	ate rar	31. Date filed (Month, Day, Yea	ur) 32	_	trar's Signat	ure	Anask									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 008 **Physician** June 24, Barbara A. Hulley 4:30 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 19, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1950 Washington, DC Hours Min. Months Days 58 Jan. Director 227-70-6268 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
This filem 27 is marked other than "natural", or items 23a or 28a-f show this fraith and the training to the shown any or other tranmatic event, the Marical Exprine mast be notified at any or other tranmatic event, the Marical Exprine mast be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Prince George's Fort Washington 1 Tes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20744 13405 Caribou Court U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Management Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Octavia Spinner Lindsey Lee Cook ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13405 Caribou Court, Fort Washington, MD 20744 William F. Hulley - husband Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Ft. 6/28/08 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cem. 22. Name and Address of Facility Bell & Johnson Funeral Home P. A. 6503 Old Branch Ave., Temple Hills, MD 20744 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final disease or condition resulting in death) Physician MREA MEMISTANC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Examin Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed2 1 Yes 2 No deatn≀ 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 24. June 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE SOL

Registrar

State

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BARBARA 6/24/08 430 AM

ARDIYN

31. Date filed (Month, Day, Year)

BETHESDA MD JUST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day WILLIAM R. HAZELL June 22, 2008 11:25 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's <u>VILLA ROSA NURSING HOME</u> Mitchellville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05-05-1921 Birthplace (State or Foreign Country) 5. Social Security Number †**⊡**₂M 2□ F 87 Cap.Heights,MD 213-16-2776 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 EYes 2 □ No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 USA 9601 Oakwood Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian. 11. Marital Status 1-{∑Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Specify: White 1 ☐ Yes 24⊡No Specify: 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Carpenter 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Frances Williamson Robert Milton Hazell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lanham, Maryland 20706 Sharon Hancock/daughter 9601 Oakwood Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 11 Burial 2 ☐ Cremation 3 ☐ Removal from State 06-27-2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01246 Nock-Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of): Arthrosclerotic Cardiovascular Disease Sequentially list conditions, Year use of death? 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy

Physician /Medical Examiner

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'natural'

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Ite M. Once.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day
	ons contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cau

1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D32261 06-24-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9500 Annapolis Rd. #A-4 Lanham, Maryland 20706 Richard J. Feldman, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 2 5 2008



			for State of N State of N Registrar	1arylan		artment of F ctificate of		Mental Hy	giene, Reg. No.	2008	2	1933
	Physici /Medi		Decedent's Name (First, Middle, Last) Edward Willia	m Hod	ges			2. Date of De Month June	eath Day			of Death
)	Examin Funeral Director		219-30-1874 ^{1ÄM 2□F}		last birthday) Yrs.		r Location of Deaterryville If Under 24 Hrs Hours Min.	8. Date of Bi	reto.	0.00	cil place (State intry) irylan	or Foreign
	anyland show	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo						10d. Inside	City Limits
	with the M sa or 28a-f t be notifie	I Director	Maryland Cecil 10e. Street and Number 401A Carter Court			10f. Zip Code	rryville		10g. Citiz	zen of What Cou	intry?	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1. Marital Status 1. Never Married 2 Married 1. Never Married 2 Married 1. Yes 2 Married 1. Yes 2 Married 1. Yes 7 Married	s? 3 No	'	Was Decedent of H f Yes, specify Cuba		Specify Yes or Noto Rican, etc.)	0-	14. Race - Ameri Black, White	ican Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Ten Years College (1-4or		16a. Deced (Give life, L	lent's Usual Occup kind of work done DO NOT use retired Labo	ation during most of wo orer	rking	Mt.	nd of Business/Ir Ararat t Deposi	Farms	
and 2	d be filed ental Hygi ced other c event, t	Be	17. Father's Name (First, Middle, Last) John Daniel Hodg	es S	r.		18. Mother's Nar		e, Maiden			-,
Maryland	id 2 should the and Me 27 is mark traumation	은	19a. Informant's Name/Relationship (Type. Print) Henry L. Hodges, Sr. (bro		19b. Mailin	g Address (Street	and Number or Ri	ural Route Numb	ber, City or	r Town, State, Zi		
Baltimore,	Pages 1 an nent of Heal ant: If item 2 ary or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. P	Place of Disposemetery, cren	Henbird Lan sition (Name of natory or other plac y Cemeter	ce)	Date	20c. Lo	a 17601 cation - City or T Deposit		yland
Balti	permit. Departn Importa any Inju		21. Signifure of Funeral Service Licensee	E CO	I Pe	Name and Addresse A. Paterryville	. Marvla	Son Fur	' neral 03-07	Home,		
, constant	Physician /Medical Examiner ial-transit	Examiner	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiate events resulting in death) Last Due to (or as Due to	s a consequ	uence of):	diopulm Eronary				se	Approxim Interval B Onset and	etween d Death
s, P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the bunal-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contributing to death	2 Fetal at time of de	I death 3 = eath 5 =	Ectopic pregnancy Other (specify) derlying cause give		23e. Did		33d. Date of deliving Month	Day	Year
Vital Records,		Completed						24a. Was	an	No 3 □ Pro 24b. Were autorized to cool death? 1 □ Yes	opsy finding ompletion of	nknown s available cause of
7 Or	ng Phys ter this neral dil	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	jury ay Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Work	4 LI Nursing H		idence 6	i	fy)	
DIV	pltal or At ours after d leral Direc filled in by		determined 200, Flace of III	etc. (Specify	′)	et, factory, office	no deta and all	City or To	wn, State)			mber,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fur	Medical	(Check only one) 2 Medical Examiner: On the basis and manner s 29b. Signature and time of certifier	of examinat	tion and/or inv	29c. License	pinion, death occu 	urred at the time.	, date and 29d. Date	place, and due to	Day, Year)	
}			30. Name and address of person who completed cause of	death (Item	23a) (Type, F	Print)	63981		June	1,23, 2 sac	2008	2/-2:
	Sta Registr	٠.		trar's Signat	ture de	trunst	<u>.</u>	avre oly	209	sace,	MP	2018

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6 **Physician** 2008 George William Hund 5:03 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 807 Ocean Parkway Ocean Pines Worcester If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7/23/1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** MXM 2□ F 75 141-24-9445 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director MD Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 807 Ocean Parkway 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 h and Mental Hygiene.
7 Is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Postal Clerk U S Post Office 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be George Hund Esther Fogelin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar of Item 27 is 807 Ocean Parkway, Ocean Pines, MD 21811 Judith Ann HUnd / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of H Important: If its any injury or o once. 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 6/24/2008 Cape Henlopen Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 108 William St., 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final MOIOVAR CRUCAR ISSOR **Physician** THENO SCLENGTO disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Von INSULIN use as the burial-tran and Due to (or as a consequence of) Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy has certificate 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No al or Attendi s after death. death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Hospital

BA 10

State Registrar

Medical

29a. Certifier

296. Signature and title of certifie

31. Date filed (Month, Day, Year) JUN 2 4 2008

apocom any Bul 10324 32. Begistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

State of Maryland / Department of Health and Mental Hygien State
Registra MEND#20bperINF6-24-08,bMV,MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2008 CONSTANCE HARDEN JUNE 6:50 A 16, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🂢 F Yrs. Director WEST VIRGINIA 578-38-0650 JUNE 19,1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at Yes 2□No Director PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Iteme 23a U.S.A. 7205 Funeral 24th AVE. 20783 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 11. Marital Status 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Completed by Specify: 3 Widowed 4 Divorced "natural", BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) Coflege (1-4or 5+) FED. GOV'T. 5+ ADMINISTRATOR and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALONZO 2 HARDEN SR. BESS MARIE ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 to any injury or other tratence. CARDENAS/NIECE 7205 24th AVE., HYATTSVILLE, MD. 20783 GAIL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2√ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-24-2008 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset,and Death Immediate Cause (Final Metastatic Breast Cancer **Physician** disease or condition resulting in death) unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physicien and for use as the buriat-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign 1 be Hypertension Alzheimers been sig 1 Yes 2 No 3 Probably 4 Unknown typercholestero 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 200 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ŝ 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 061007 June 16, 2008 30. Name and address of perso w Kenneth Khandagle who completed cause of death (Item 23a) (Type, Print) Silver Spring, MD 20903 831 E. University Blvd 井25 . Registrar's Signature 31. Date filed (Month, Day, Year) State 2 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ^{Day} 2008 **Physician** Harry Leroy HAMBY June 26, 5:20 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13942 Weaver Avenue Washington Maugansville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 90 214-09-9828 Maryland Director 21, 1918 April Usual Residence of Decedent 10c. City, Town or Location 10b, County 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No Director Maryland | Washington Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 13942 Weaver Avenue 21767 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WW I I 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) engineer railroad permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If item 27 is marked other any injury or other trainman. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry V. Hamby Susie Florence Bingaman 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Hawbaker - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 6/30/08 Hagerstown, Maryland 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME tred L. Vestas 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (CO) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 Tes 6 Could not be 3 ☐ Suicide

the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician; Hospital or Attending

sician and burial-trans attending physician as the l asn ned by the atten e detached for u certificate after death. I Director: After this in by the funeral within 24 hours a completely filled

show

death \

within 72 hours after

Hygiene.

Baltimore, Maryland 21215-0036

DH-15+

the

State Registrar

Medical

4 Homicide

29b. Signature and title

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Faminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

			For State Registrar	State of Marylar		artment of H rtificate of L		Mental Hyg	jiene leg. No. 20	08	21937
-¥.	Physici		Decedent's Name (First, Middle, Las Ronald	Eugene		Household	der	2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	JUNE	4c. County	008 of Death	7:12 A
	Funeral Director		210-30-0070		last birthday) Yrs.	CUMBER If Under 1 Year Months Days		8. Date of Birth (Month, Day 05 / 14 /	r, Year)	EGANY 9. Birthpl Coun: Mary	ace (State or Foreign fry)
	land ow t		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				11	Od. Inside City Limits
	Mary -f she fled a	tor	MD All	egany	Cum	berland					1 □Yes 2 □XNo
	th with the 23a or 28a ist be noti	al Director	10e. Street and Number 11718 Eastman			10f. Zip Code	21502		10g. Citizen of V US		try?
036	within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notitled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 1 Yes 2 □ No If Yes, Give Konean Year or Dates. War		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🗓 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race Blace Specify	e - America k, White, o	
215-0036	ithin 72 ho ne. nan "natur e Medical I	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of work)	king	16b. Kind of Bu		·
7	filed within Hygiene. Ither than "ent, the Med	Š	12 17. Father's Name (First, Middle, Last)			Installe	18. Mother's Nam	ne (Firet Middle	Tele		
Maryland	d tal) Be	Grayson	Odell H	louseho	older	Violet		manden Suman rginia	•	ville
<u>Z</u>	2 should be and Menta Is marked sumatic ev	으	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)
	2 2 2 8		Helen L. Househol	der / Wife	1171	8 Eastmar	n Road, N	NE., Cum	berland	, MD	21502
Baltimore,	of fer in		20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer mberlar	osition (Name of matory or other place ad Cremato	ory 06/		20c. Location - Cumbe	rland	ı, MD
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	idams		2. Name and Addres 404 Decati			•		Home, P.A. 21502
	Physician /Medical Examiner	_	23a. Part Deliver the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to or as a conse.	quence of):	()	g, such as cardiac		rest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
O. Box 6	death certif e attending d for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	aldeath 3 🗆	□Ectopic pregnancy □ Other (specify)			1	te of delive	ry Day Year
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r	The law ate has b page 2 sl	Completed by	,	•				24a. Was autop perfor 1 Yes	rm ę d?	prior to cor death?	psy findings available npletion of cause of 2 No
VIta	Physician; this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ER/Outpatier	nt 3 DOA Othe	er.	th (Check only o			
on or	ر ا		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury	4 Nursing H	ome 5 ☐ Resid			v)
DIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, str	reet, factory, office		28f. Location (S City or Tow		er or Rura	l Route Number,
	he Hospi n 24 hour he Funer bletely filli	edical	(Check only 2 Medical Exam	ysician: To the best of my kniner: On the basis of examination and manner stated.	ation and/or in	ivestigation, in my o	pinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
,	Vithin +	M	29b. Signature and title of certifie	ntam		29c. License	e number		29d. Date signe June	d (Month,	Day, Year)
	nd Sta	te	30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of death (Itel	n 23a) (Type,	Ave.,	uite	101, 0	lumbe	erla	+ND, Mol
	Registr	ar	JUN 1 8 201	18 James 1	O A						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jun 28, 2008 7:07 am[™] Deborah Pauline Haines /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14300 Jared Drive SW Lot T Cumberland Allegany 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2□ F Sep 3, 1956 216-72-6600 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MD Allegany Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be r 21502 USA 14300 Jared Drive SW Lot T Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: ð Specify: 3 ☐ Widowed 4X Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be the Health and Mental is marked Otis Watts Jr. Laura Lea Evans Watts traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14300 Jared Drive SW MD 21502 : If item 27 is or other tra Raymond Haines II Cumberland son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
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any injury or ott 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 7/2/2008 MD Cresaptown 4 Donation 5 Other (Specify) 21. Signature Fun ral Septo Lio 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Dent Finter the disease, or com shock, or heart failure. List only Immediale Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. METASTATIC LIVER CANCER Physician MONTH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 month 1 ☐ Yes 2 ☐ Mo Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2 1 certificate has 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Yes 20 1 | Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Aatural 5 Pending investigation n 24 hours after death.

e Funeral Director; Af
bletely filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Dentitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely one, and manner stated within 2

State Registrar

29b. Signatu

31. Date filed (Month, Day,

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2. Registrar's Signature /

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		5. Time of Death
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	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h 9, Birt	hplace (State or Foreign
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	h the	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Co	untry?
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	er dez	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of H If Yes, specity Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White	
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121	e filed wi Il Hygier other th			x Auditor		(First Adiddle	IRS Maiden Surname)	
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Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposemetery, creation 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of ematory or other place	ce)	Date	20c. Location - City or	Town, State
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Bai	permit. Pages Department of Important: If i any Injury or once.		MD/J4/	22. Name and Addre	-	DA Arro	Suitland,	MD 20746
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	/Medical		disease or condition resulting in death) a. Due to (or as an sequence of):	neu	20-1	uuu		
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π. σ.	Attending Physician: The law requires that the death certific radeath. radeath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as it.		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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	To th To th сощр	Me	29b Signature and title of certifier	29c. Licens	e number	0 2	29d. Date signed (Month	n, Day, Year)
			29b. Signature and title of certifier B. Wassers A. D.	200	5694	9	6/20/0	4
Ø.			30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)	. 11	C-1-	1 2014	P- 77 HD-2064
	Sta		/ KA TAKSH (BAIQ HD 66 31. Date filed (Month, Day, Year) 32. Registrar's Signature	20 CRAIN	s Holl,	STER	DZ , LAYLI	The state of

Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** David Jerome Irick June 20 2008 :50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Prince Georges Cheverly 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1**⋤**M 2□ F Months Days Director 216-08-7811 Dec.22,1970 Wash., DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No PG Md. Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9703 New Orchard Drive Funeral 20774 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ 1989-3 Widowed 4 Divorced Black 1993 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, If and price. Elementary/Secondary (0-12) College (1-4or 5+) <u>Accountant</u> Private 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Samuel ျှ Irick <u>Yvonne Douglas</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9703 New Orchard Drive
Largo, Md. 20774

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 19a. Informant's Name/Relationship (Type. Print) Yvonne Irick/mother 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md, Veterans Cem. 6/30/08 Cheltenham, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Kd., Suitland, Md. 20746 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Duremia /Medical Due to (or as a consequence of): Examiner meumonia Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Yea signed by the ar 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐NO 9 I Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>გ</u> teolure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed metaholic acriclosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s Retroviral perform certificate 2 1100 1∐Yes 2.2MNo 1 □ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 410 Hospital: 1 Inpatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural in 24 hours and the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) πpletely the the To the Within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State JUN 2 3 2008

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32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6/20/08

Hospital DR. Cheverly Md 20785

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:40 AM 2008 Maurice Mallory Johnson June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🖾 F Director 579-44-7721 87 3, 1921 Virginia Jan. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State ed other than "natural", or items 23a or 28a-f show event, the Medical Evaningr must be notified at Director 1X Yes 2 □ No DC N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20012 400 Whittier St., N.W. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No ģ Specify: Black 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher 4 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otis Mallory Injury or other traumatic ပ Sarah Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Carlton V. Johnson / Son 3304 Strawberry Hill Dr., Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/24/2008 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat. Cem. Laurel, MD 21. Signatury of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician metastatic Aduanced disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month P.O. 1 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 412heimer's di seus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation hours after death. 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

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Funeral Director			6. Sex 1 □ M 2 X F	7. Age (In yrs. 97	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Birth Day, Ye.	9. Bir 1910 Lond	thplace (State or Foreign punitry) Con, England	
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permit. 1 ages 1 and 2 leath a Important: If item 27 is any injury or other training once.		21. Signature of Funeral Service L			22			ee Fune		Home Cal	Lvert, PA	
1		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that only one cause on	each line.	h. Do not ent	er the mode of dy		-			Approximate Interval Between Onset and Death	
hysician /Medical xaminer		disease or condition resulting in death)		(or as a conseq	,							
and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): CONGESTIVE NEART FRICURE Due to (or as a consequence of):										
physicia the bur	dical		d									
within 24 fours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 9 □ Unknown	1 ☐Live	utcome pf pregna birth 2 Feta prant at time of d nown	ıldeath 3□	Ectopic pregnand Other (specify)	БУ		-	23d. Date of de Month	elivery Day Year	
an signed by	ò	Part II. Other significant condition HYPERTENS (TEORR			ven in Part I.		d tobaco		o the cause of death?	
cate has been page 2 sho	Completed							24a. Wa au pe 1□ Yes	topsy rformed	death?	utopsy findings available completion of cause of s 2 No	
certifi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	N 0	ER/Outpatier	t of box Ot	hor:	eath (Check on				
h. After this funeral di	ion: To	27. Manner of Beath 1 Natural 5 ☐ Pending	28a. Date		28b. Time o	f 28c. Inju	4 🗆 Ivuisiiy			e 6 □Other (Spenjury occurred	ecity)	
after deat Director: I in by the	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	e of injury - At ho ding, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location City or 7			ural Route Number,	
24 hours e Funeral	edical C		g Physician: To th Examiner: On the l and mai									
within To the compl		29b. Signature and title of certifier	am	exel 1	40	29c. Licen	se number D50233		29d.	Date signed (Mon	th, Day, Year)	
) /2	-	30. Name and address of person v		,	, , , , ,	Print) Road Pr	rince Fr	ederick	MD			
State Registra		31. Date filed (Month, Day, Year)		Registrans Signa	ature	Sperke	p	302 4043	, 2,122			

State of Maryland / Department of Health and Mental Hygiene 2008 21943 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jun 29, 2008 James Sr. 12:44am™ Henry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland Allegany Golden Living Center f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb 29, 1920 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 M 2 □ F Director 220-10-7625 88 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural", or Items 23a or 28a-f show be notified at MD Allegany Cumberland 1 TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 14611 McMullen Hwy. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Kilyes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ **X**o þ Specify: 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1,2 College (1-4or 5+) auto mechanic auto industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Estaline Eshbaugh James Howard James ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 Eleanor Pennington 14611 McMullen Hwy. Cumberland daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/3/2008 Scarpelli Funeral Home, P.A. Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licer 108 Virginia Avenue: Cumberland, MD 21502 23a. Fort1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failbre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final Carcinona Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death. To the Funeral Director: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of 29c. License number 120033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

625 KENTAVE.

- D.

32. Registrar's Signature

Physic /Med Exam Funera

Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1 - For State Registrar	Ce	rtificate of D			Reg. No. 2	800	219	344
ian	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	Year	3. Time of D	
ical	ADALBERT PETER KOPEC, III		45 City Town and	and an of Dooth	JUNE	21	2008	1:30	P M
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L				y of Death	ric	
	621 DAVOL ROAD 5. Social Security Number 6. Sex 7. As	ge (In yrs. last birthday		NSVILLE If Under 24 Hrs.	8. Date of Bir		EN ANN 9. Birthpla	ce (State or I	Foreian
	218-60-7555 1MM 2□F Usual Residence of Decedent	39 Yrs.	Months Days	Hours Min.	JULY 1	year) 9. Birthplace (State or Foreign Country) MARYLAND			
	10a. State 10b. County	10c. City, Town or L	ocation				100	I. Inside City	Limits
ctor	MARYLAND QUEEN ANNE'S	S	TEVENSVILL	E				1 ☐ Yes 2	² ▼ No
)ire	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Country	/?	
<u>ra</u>	621 DAVOL ROAD			1666			TED ST	ATES	
y Funeral Director	11. Marital Status 1 □ Never Married 2 M Married 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces' 1 □ Yes 2 M If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🗶 No		ecify Yes or No Rican, etc.)		ice - Americar ack, White, et ify: WHITE	o.	
Be Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupat e kind of work done du DO NOT use retired)	ion Iring most of work	ing	16b. Kind of E		stry	
Ę	Elementary/Secondary (0-12) College (1-4or	5+)	LECTRICIAN				RUCTION	1	
ပိ	17. Father's Name (First, Middle, Last)			8. Mother's Name	e (First, Middle,	l , Maiden Surna	me)		
To B	ADALBERT PETER KOPEC, JR			CAROLYN	ELIZAB	ETH FAR	REN		
	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street ar	nd Number or Run	al Route Numb	er, City or Towr	n, State, Zip C	ode)	
	VICTORIA KOPEC/WIFE		1 DAVOL ROA	AD, STEV	ENSVILL	E, MARY	LAND 2	1666	
	20a. Method of Disposition 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp CHESAPEA CEN	KE CREMATI	ON JUNE 200	23, 08	20c. Location	•		AND
	21. Signature of Funeral Service Licenses		ELLOWS, HEL 06 SHAMROO	FENBEIN K ROAD,	AND NEW	NAM FUN R, MARY	NERAL E	OME, 1	P.A.
	23a. Part 1. Sater the disease, or complications that cause shock, or heart failare. List only one cause on each I	rrest,	l t	Approximate nterval Betwe					
	Immediate Cause (Final disease or condition	9 can	cer				2.	onset and De	eath Lass
	resulting in death)	consequence of):							
l,	Sequentially list conditions, b.								
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ulsease or injury.								
Examine	Cause (Disease or injury that initiated events resulting in death) Last C	a consequence of):							
les H	d								
Medical	u.								
by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	ate of delivery lonth D		ear					
y P	Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause giver	ı in Part I.	23e. Did t	obacco use cor	ntribute to the	cause of dea	ath?
d be					10	Yes 2 No	3∏ Probal	oly 4 □Un	iknown
Completed						psy ormed?	. Were autops prior to comp death?	oletion of cau	/ailable use of
Be C	25. Was case referred to medical			26. Place of Death	1 Yes h (Check only o	2 No	1 □ Yes 2	□ No	
To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatie	Othor				ther (Specify)	•	
ü	27. Manner of Death 1 Natural 5 Pending (Month, De		of 28c. Injury : Work?	at		how injury occu			
catic	2 Accident investigation			es 2□No					
Certification:	determined 200. Flace Util	jury - At home, farm, st tc. <i>(Specify)</i>	treet, factory, office		28f. Location (City or To	Street and Num wn, State)	iber or Rural I	Route Numbe	er,
Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of my knowledge, dea of examination and/or i tated.	th occurred at the time nvestigation, in my opi	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as sta e, and due to t	ted. he cause(s)	
M	29b. Signature and title of certifier	>	29c. License	number 9505		29d. Date sign	ed (Month, D.	200	8
	30. Name and address of person who completed cause of a wall of the complete cause of the cause of the complete cause of the complete cause of the cause of	death (Item 23a) (Type	Print)	ov, Gle	n Bu	mire	MI	210	061
ate rar	31. Date filed (Month, Day, Year) 32 legist	rar's Signature	mente						

Registrar

			_ FOI	partment of Health and Ment ertificate of Death	tal Hygien Reg. N	^{le} 2008 21945
	Physici		1. Decedent's Name (First, Middle, Last) Edna C. Kelbaugh			Oay Year 3. Time of Death
mar.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
- 1			Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Hagerstown y) If Under 1 Year If Under 24 Hrs. 8, Da	ate of Birth Month, Day, Yea	Vashington County 9. Birthplace (State or Foreign Country)
	Funeral Director		216-76-7579 1 M 2X F 72 Yrs.	Months Days Hours Min. (A		935 Maryland
	ryland ihow	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits 1
	the Marylar 28a-f show	Director	Maryland Washington County Hagerston			
	with th		10e. Street and Number	10f. Zip Code		Citizen of What Country?
	eath rs 23	Funeral	1500 Pennsylvania Ave. 11. Marital Status 12. Was Decedent Ever in U.S. 13	21742 3. Was Decedent of Hispanic Origin? (Specify Y		3 • A • 14. Race - American Indian,
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medial Examin	ò	Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican □ Yes 2 No Specify: 	n, etc.)	Black, White, etc. Specify: White
21215-0036	n 72 ho " natur	letec	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	16b.	Kind of Business/Industry
	filed within Hygiene. other than "	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	er Worked		
Maryland	2 should be filed w n and Mental Hygie ris marked other t raumatic event, In	Be	17. Father's Name (First, Middle, Last) Stanley W. Kelbaugh	18. Mother's Name (Firs		, and the second
ary	shoul and M s marl	2		illing Address (Street and Number or Rural Rou		
\geq	1 and 2 Health a em 27 is other tra			W. Franklin St. Hager	stown,	MD 21740
nore	Pages 1 anent of He ant: If iten		1 D Burial 2 L Cremation 3 L Removal from State	position (Name of Park Nematory or other place) vn Mem. Park 6-25-20		Location - City or Town, State .liamsport, Maryland
Baltimore,	permit. Pages 1 ar Department of Hee Important: If item any Injury or othe once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Dougl 1331 Eastern Blvd. Nor	as A. F	Tiery Funeral Home
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or hgart failure. List only one cause on each line.			Approximate Interval Between
and.	Physician		Immediate Cause (Final disease or condition Sepsis Second or	y to Winary Tr	aci I	infection Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
,	execute n and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c			
68760,	ificate be executed g physician and as the burial-transit	edical I	d			
			IF FEMALE: 23c, If yes, outcome of pregnancy			22d Date of delivery
.O. Box	Physician: The law requires that the death certificate this certificate has been signed by the attending it director, page 2 should be detached for use as	Physician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that s been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2☑No 3☐ Probably 4☐ Unknown
of Vital Records,	: The law re cate has bee , page 2 sho	Completed	Decirios Meraicon of R	ignt hip/heel	24a. Was an autopsy performed?	24h Were autopsy findings available prior to completion of cause of death?
tal	iiclan: Th certificate ector, pag		25. Was case referred to medical	26. Place of Death (Che	1 □Yes 2 🗹	No 1 □Yes 2 □No
ξ	ysiclan: iis certific director,	To Be	examiner? 1 Yes 2 No Hospital: 1-Inpatient 2 ER/Outpat	Other:		6 ☐Other (Specify)
o uc	ding Phys h. After this of funeral dire	ion: 1	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 28b. Time (Month, Day, Year)		Describe how in	jury occurred
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. L	ocation (Street Dity or Town, Sta	and Number or Rural Route Number, ate)
_	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and o	due to the cause	e(s) and manner as stated.
	he Ho in 24 t he Fui pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at	the time, date a	and place, and due to the cause(s)
	Voith Com	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
			Small Develo	11006[1]	Ju	me 23, 2008
3	41		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print) 231 t. 12 t. 1	MD	21740
	Sta Begistr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.1		

ORIGINAL

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

JUN 2 0 2008

32. Registrar's Signature

attending physician and for use as the burial-transit e Hospital or Attending Pl 24 hours after death. e Funeral Director; After ti

Completed

Be

P

Certification:

Medical

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 ☐ Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

LAVALE, MARKEAND

death?

23d. Date of delivery

Day

Year

Month

1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certification 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES R. MOEN, MO 168 NATIONAL HIGHWAY

6 Could not be determined

DJJY(7 (MANTENSE) 29d. Date signed (Month, Day, Year)

JULY 380, 2008

AMES R. MOEN, 31. Date filed (Month, Day, Year)

3 Suicide

4 ☐ Homicide



DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Fern A. Lockard June 20 2008 5:40p 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Manchester Long View Nursing Home Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🖾 F Months Hours Min. 218-26-9456 July 13, 1931 Md Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2√ No Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15433 Dover Road 21155 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify.White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home

18. Mother's Name (First, Middle, Maiden Surname)

Snyder

20c. Location - City or Town, State

21074

Day

1 ☐Yes 2 ☐ No

3 Probably 4 Unknown

Year

Approximate Interval Between Onset and Death

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Paul's Cemetery 6/25/08 Arcadia, Md. 22. Name and Address of Facility Fline Funeral Home

15433 Dover Road, Upperco, Md. 21155

934 S. Main St., Hampstead,

Helen

Physician /Medical Examiner

1 - State Registra

10a State

MD

12

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

17. Father's Name (First, Middle, Last)

Andrew Trumpower

19a. Informant's Name/Relationship (Type. Print)

4 Donation 5 Other (Specify)

Landa

Charles G. Lockard,

of Funeral Service Licensee

1 Burial 2 Cremation 3 Removal from State

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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items 23a

"natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Me any Injury or other traumatic event, the Me any Injury or other traumatic event, the Me any Injury or other traumatic event, the Me any Injury or other traumatic event, the Me

Director

Funeral

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Completed

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traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physlcian: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transh certificate has b within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month: Day, Year) H0061206 30. Name and address of person who completed/cause of death (Item 23a) (Type, Print) TRACIE L. 31. Date filed (Month, Day, State Registrar **ORIGINAL**

husb.

Due to (or as a consequence of):

Due to (or as a consequence on

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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

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20b. Place of Disposition (Name of cemetery, crematory or other place)

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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

show notified at

7 28a-f

death with the Maryland

Vame: Lavrenchik,

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be 1 once. Baltimore, Maryland 21215-0036 19a. Informant's Name/Relationship (Type. Print) HELEN V. LAVRENCHIK, SPOUSE 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Pal 1. The the line se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Vedre 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIDTI 21713 301-432-8470 20311 Lappans Road Boonsboro, MD Dr. Ghazala Oadir 32. Reistrar's Signature 31. Date filed (Month, Day, Year) **JUN 25** 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Registrar

State

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Tsaac McDonald Jordan June 20, 2008 5:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Ft. Washington 1107 Palmer Road #3 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 18, 1983 6. Sex Birthplace (State or Foreign Country) Funeral Months Days 1 XX 2 □ F 228-27-5503 25 Yrs. Director Virginia Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Prince George's Ft. Washington Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? tem 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be n 1107 Palmer Road #3 20744 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. Yes 2xxNo Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXVio þ Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Hotel Industry permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofth any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jordan Roberta McDonald Jessie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ember McDonald/Wife 1107 Palmer Road #3 Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gift Registry 06/20/2008 Glen Burnie, Maryland IX Donation 5 Other (Specify) 21. Signature of meral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1 Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer of Newsendocrine 20 months resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2**X**X No 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2XXNo 1 ☐ Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Certification: 1XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number MD33027 30. Nam and address of erson who completed cause of death (Item 23a) (Type, Print) Reservoir Road Vastighan DC Toler Purnam, MD Lombara Concer Cente 31. Date filed (Month, Day, Year) 32. Registrar's Sig State

DHMH 17 Rev 1/2001

Registrar

JUN 2 3 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** James Lawrence McCumber 9:30 A M 2008 21 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Westminster Dove House Carroll 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 X M 2 □ F Director 212-52-3477 60 March 25, 1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County a or 28a-f show t be notified at 28a-f show 1 ☐ Yes 2√√No Director MD Carroll Sykesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number urai", or items 23a o Examiner must by 1099 Montclare Dr. items 23a 21784 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1XXes 2□No 1968 -If Yes, Give 1971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White þ 3 Widowed 4 Divorced 'naturai", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 12th Northrop Grummen Inspector Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, <u>tt</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Troy McCumber Vivian Loughry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia McCumber (wife) 1099 Montclare Dr. Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages -1 → Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Lake View Memorial 6/24/2008 Sykesville, MD 22. Name and Address of Facility
Ourrier-Queen Funeral Home and Crematory, P.A. d the death. Do not enter the mode of dying, such as pardiac or respiratory arrest.

1212 W. Old Liberty Rd. Winfield, MD 2170/
o imate Interval Between Onject and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2FINo 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 page perform certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After or Attending 5 Pending investigation 1 Natural To the Hosping.
within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ure and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa on who completed cause of death (Item 23a) (Type, Print) Center St. Westminster, modi 555 19010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 3 Registrar 2008

State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 2008 20 9:45P Virginia Naomi Minnick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Lutheran Health Care Center Carroll Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Feb. 25,1908 5. Social Security Number 6. Sex **Funeral** Hours 1 □ M 2 🔀 F 100 Director 214-01-0693 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Madical Examinations by nothing at 1 XYes 2 No Director Maryland Carroll Union Bridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 107 N. Main St. 21791 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify. Specify. 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 editor newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Howard S. Shipley Emma Kate Geiman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William B. Dulany/ executor Westminster, MD 21157 127 E. Main St. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2XXCremation 3 ☐ Removal from State County Cremation 6/21/2008 4 Donation 5 Dother (Specify) A11 Sykesville, MD 22. Name and Address of FacilityHartzler Funeral Home 21. Signature of Funeral Service Licen 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy 5 ☐ Other (specify) P.O. detached 9 Unknown q □ Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 □Yes 2 □No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D52035 WIL 2008 15 30. Name and address of person who completed cause of death (Jtem 23a) (Type, Print) Westminsta Stoner DINU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINIAL

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 22^{Day} 2008 SUSAN ANNA MCDERMOTT 12:53 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE CENTER OF QUEEN ANNE'S QUEEN ANNE'S CENTREVILLE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month. Day. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🗙 F 49 NOVEMBER 10,1958 VIRGINIA Director 219-70-8743 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ORANGE ORLANDO FLORIDA 1**X** Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32820 UNITED STATES 16937 CORNER HILL COURT Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: WHITE 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be PATRICIA DEIHR ALAN MCDERMOTT ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16937 CORNER HILL COURT, ORLANDO, FL 32820 PAULA KENNELL/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JUNE 23 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral 9 ervice License FELLOWS, Addition FERREIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. disease, or complications of Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart fa Immediate Cause (Final **Physician** disease or condition resulting in death) Rectal CONCER 6 mas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 2**X** No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe or Vital To the Hospital or Attending Physician: certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? HOSPICE HOUSE Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 | Inpatient Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred After (Month, Day Year) Division 1 Natural 5 Pending investigation 1 Yes 2 No neral Director: A filled in by the fi 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID C. HALVERSON, M.D. 8221 TEAL DRIVE, SUITE 302, EASTON, MD 21601 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 9:30 P M 22 Wilma E. McGill 6 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/27/1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1□ M 2√ F 215-66-8380 79 Germanv Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Modical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director Ocean Pines MD Worcester 10g. Citizen of What Country? 10e. Street and Number 21811 USA 17 Serf Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🛣 No 21215-0036 Specify: white 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Elasa Maria Vohringer Karl August Ruf ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 Serf Place, Ocean Pines, MD 21811 Department of Health a Important: If item 27 is any injury or other tra Rodney McGill / son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 6/23/2008 | Frankford, DE 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causy in each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ue to (Vas a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 MNo 9 ☐ Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed, 2 No 1 ☐ Yes 2 □ No 1 □Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my existing the control of the cause (s) and manner as stated. 29a. Certifier Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) impanner stated. Medical Examiner: On 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BA 10

DHMH 17 Rev 1/2001

State

Registrar

(Month, Day, Year)

JUN 2 4 2008

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			State Registrar	Maryland / Depa	rtificate of D	eath	Reg. N	0.00	21956
	Physicia		1. Decedent's Name (First, Middle, Last) Ghassem Shater Mobin			M	ate of Death onth D ne 20,	yay Year 2008	3. Time of Death 11:00 A.M
No.	/Medic Examin		4a. Facility Name (If not institution, give street and nur	nber)	4b. City, Town, or L			c. County of Death	
may 5			3227 Park View Road		Chevy Cha	ase	M	lontgomery	
ij	Funeral Director		578-56-6556 1 [™] 2□F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	Hours Min. 8. Da	ate of Birth fonth, Day, Yea B. 24,	1934 Iran	place (State or Foreign ntry) 1
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	to	Maryland Montgomery	Chevy Cha	se				1 □Yes 2 No
	th the	Director	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Cou	ntry?
	23a ust b	ral	3227 Park View Road		20815			ted State	
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the fredical Francian in the matter or other traumatic event, the fredical Francian is a matter or other traumatic event, the fredical Francian is a matter or other traumatic event, the fredical Francian is a matter or other traumatic event, the fredical Francian is a matter or other traumatic event, the fredical Francian is a matter or other traumatic event.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Dece Armed Fo 1 □ Yes If Yes, Giv Year or D.	2 ∑ No ve .	**	panic Origin? (Specify Y , Mexican, Puerto Rican Specify:	es or No- , etc.)	14. Race - Ameri Black, White, Specify: As i	etc.
2-0	72 hou natura fical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat	tion uring most of working	16b.	Kind of Business/Ir	ndustry
121	/ithin /ithin ine.	mpl	Elementary/Secondary (0-12) College (1	-4or 5+) life. L	DO NOT use retired)		En		
5 0	filed w Hygie other t		17. Father's Name (First, Middle, Last)	Archi		18. Mother's Name (Firs		gineering en Surname)	<u> </u>
lan	ld be lental ked o ic eve	To Be	Hussein Mobin			Zarah Jansh	ahai		
ary	should and Men is marke		19a. Informant's Name/Relationship (Type. Print) W	ife 19b. Mailir	ng Address (Street ar	nd Number or Rural Rou W Road MD 20815	ite Number, Cit	y or Town, State, Zi	p Code)
Σ,	is 1 and 2 and Health a litem 27 is		Luz Estella Gutierrez Mo						
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Healt Important: If item 2' any Injury or other once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from	State	osition (Name of matory or other place,	June 1	,	Location - City or T	
ΞĒ	nit. Pa artmer ortant Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22	Mem. Parl	of Facility	15.	ckville,	
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en	Physician		23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition	aused the death. Do not ent	ter the mode of dying				Approximate Interval Between Onset and Death 1 MONTH
	/Medical		resulting in death)	(or as a consequence of):					
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a consequence of):				_	
	uted d ansit	Examiner	Cause (Disease or injury	or as a consequence cry.					
oʻ	e exec ian an	Еха	that initiated events c Due to	(or as a consequence of):		· · · · · ·			
68760,	ficate be executed physician and is the burial-transit	edical	d						
O. Box 6	eath certi attending for use a	Physician/Me	in the past 12 months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
ds, P.	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions contributing to de	eath but not resulting in the u	inderlying cause giver	n in Part I. 2		co use contribute to	the cause of death?
oce	aw rec as bee 2 shou	Completed					24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
Ě	The I	Com				1	performed I □Yes 2 🖸	? death? No 1 □ Yes	2X No
Vita	Iclan: Sertific ector,	Be	25. Was case referred to medical examiner?			26. Place of Death (Ch			
of	Attending Physician: If death. ector: After this certifici by the funeral director, i	<u>2</u>	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ 27. Manner of Death 28a. Date	Inpatient 2 ☐ ER/Outpatien of Injury 28b. Time o		r: 4 Nursing Home	5 🔼 Residence Describe how in		cify)
O	th. : After	tion	1 Natural 5 Pending (Mon 2 Accident investigation	ith, Day, Year) Injury	Work?	? es 2□No		,,	
É	il or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place	e of injury - At home, farm, str ing, etc. (Specify)	reet, factory, office		ocation (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 burs after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Lack Certifying Physician: To the 2 Medical Examiner: On the band man	e best of my knowledge, deat pasis of examination and/or in the stated.	th occurred at the tim nvestigation, in my op	ne, date and place, and opinion, death occurred at	due to the cause the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0	29c. License	number	29d.	Date signed (Month	n, Day, Year)
	6		1600 AL	unerel	D0695	9	JUI	NE 21, 20	08
	Ψ		30. Name and address of person who completed cause			DOTOMAC MT	2085/		
	Sta	te	ELBA J. MARTINEZ, M.D., 31. Date filed (Month, Day, Year) 327	Registrar's Signature	TLLL LANE,	FOTOLIAC, MIL	20034		
	Registr		JUN 2.3 2008	and the low	and I				

			For State Registrar	State of Mary	yland / Depa <i>Ce</i>	artment of H <i>rtificate of D</i>	ealth and M Death	ental Hygie	ne 2008	3 21957
ı	Physicia	an	1. Decedent's Name (First, Middle, La William			Miller		Date of Death Month	Day Year	3. Time of Death 3:45 P
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death	June 21	2008 4c. County of Dea	
	Examin	er	13413 Chatelaine			Cumber	land		Alleg	any
	Funeral Director		5. Social Security Number 6. S 218-64-9223	Mu obs	n yrs. last birthday, 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) C	thplace (State or Foreign ountry)
Sur.	and the second		Usual Residence of Decedent					03/15/18	1)Z Irlai	
	how lat		10a. State 10b. County		Oc. City, Town or L	umberland				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ne Ma 8a-f s ptified	Director	MD Alleg	garry					000 (100) 0	11
	3a or 2 st be no	Dire	10e. Street and Number 13413 Chatelair	ne Drive, NE		10f. Zip Code	21502	10g.	. Citizen of What C USA	ountry?
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
326	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
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7	within 72 ene. than "na he Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	ng	**	
7	filed wi Hygier ther th		12 17. Father's Name (<i>First, Middle, Last</i>	A		Maintena		e (First, Middle, Ma	Hospi	tal
Maryland	ld be filental History ked otl	Be c	Albert	Charles	Mi	ller	Gertru		Zerk	el
Ž	should be nd Menta marked imatic ev	은	19a. Informant's Name/Relationship			ing Address (Street a	and Number or Run	al Route Number, C	City or Town, State,	Zip Code)
Z	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic evonce.		Gertrude Miller	Mother	1341	3 Chatela:	ine Drive	, NE., Cu	umberland	, MD 21502
altımore,	es 1 g of He fitem		20a. Method of Disposition 1 ☐ Buria! 2 X Cremation 3 ☐			osition (Name of ematory or other plac			c. Location - City o	r Town, State
Ĕ	ment ment lant: I		4 □ Donation 5 □ Other (Speci	fy)		nd Cremate			Cumberlan	
Rail	permit Depart Import any in		21. Signature of Funeral Service Lice	nsee		22. Name and Addres		-		Home, P.A. 21502
	20 2 W O		23a. Parti. Soler the disease, or comshock, or heart failure. List only	polications that caused th				·	<u>.</u>	Approximate
	Dhysician		Immediate Cause (Final	one cause on each line.	atic	Color				Interval Between Onset and Death
13	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	consequence of):	(010,	1 0011	Q		19-620
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_	and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	consequence of):					
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9	tificate g phy: as the	ledic		LU.						
Box	eath certifi attending for use as	M/ne	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2 [☐Ectopic pregnancy			23d. Date of do	elivery Day Year
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at tin 9⊡Unknown		Other (specify)			MOITH	Day Teal
О	that the		Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
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Ä	siclan; The law certificate has l irector, page 2 s	mo			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			autopsy performe 1 Yes 2	ed? death?	
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	hysic this co	은	1 ☐ Yes 2 No	Hospital:			4 LI Nursing Ho	me 5 🖾 Residen		pecify)
UC.	Aling F	ion:	27. Manner of Death D⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	/ear) 28b. Time Injury	Wor	y at k? Yes 2 □ No	28d. Describe how	injury occurred	
Division or	death death cctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined.	28e. Place of injury	- At home, farm, s		103 2	28f. Location (Stre	et and Number or I	Pural Route Number,
	al or /	Certification:	4 ☐ Homicide determined	building, etc. ((Бресіту)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours, after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	Medical (hysician: To the best of a miner: On the basis of example and manner state	xamination and/or					
	o the	Mec	29b. Signature and title of certifier	Mired		29c. Licens	e number	290	d. Date signed (Mo.	nth, Day, Year)
)	5		D	Mr.		DC	060478		June 23	, 2008
	nes	3	30. Name and address of person who Afaq Ahmad,		th (Item 23a) (Type Seton Dr	e, Print) Pive, Cumb	erland, l	MD 21502	!	
	Sta	ite	31. Date filed (Monthly, 2013) 2	, _	s Signature		,			
	Regist		3UN 2 3 7	000	N. 16					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** РМ Athalene Main June 29 2008 2113 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 346 Biddle Street Chesapeake City Ceci1 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Director 224-60-2268 68 FEB 28, 1940 Virginia Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Ceci1 Elkton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or? rai", or items 23a Examiner must b 80 Frenchtown Road 21921 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 🛣 Divorced Year or Dates: White er than "nature the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspection Technician Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willard Crockett Bandy Susie Sparks မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any Injury or other tr Dawn Jackson/Daughter 80 Frenchtown Road, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 30. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 2008 West Chester, PA 22. Name and Address of Facility
Hicks Home for Funerals,
103 W. Stockton Street. 21. Signature of Funeral Service Licensee, 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ma Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (vr as a consequence of): Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy s certificate has irector, page 2 performe 2 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month 29b. Signature and title of certifier Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 8 2008 Registrar

DHMH 17 Rev 1/2001

21215-0036

Maryland

Baltimore,

Records, P.O.

or Vital

Division

			1 - For State Registrar	State of M	aryland	d / Depa	artmen rtificat	t of H e of L	ealth a D <i>eath</i>	and M		giene Reg. No.	800	21959
E. S.	*	×	1. Decedent's Name (First, Middle, Last)							2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici Medio/		Donald Eugene	Neder							June			10:15 a _M
	Examir		4a. Facility Name (If not institution, give	street and number))		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Death	
	·		Lark and Chase Num				Bow		W17-32-7	04 (1			nce Geo	
	uneral rector		5. Social Security Number 6. Se	x 7. Ag ≸M 2□F	ge (In yrs. Ia		If Under Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da	th y, Year)		place (State or Foreign ntry)
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yland	how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
ө Ма	Sa-f s	ctol	MD Prince G	eorges	Mt.	Rain	ier							1X Yes 2 No
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ath w	8 238	a	2900 Taylor Street					207					USA	
21215-0036 bd within 72 hours after death with the Maryland giene.	Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event. It e Medical Examinat must be notified at 20ce.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Year or Dates:	?		Was Decec If Yes, spec 1 Yes		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)	-	I. Race - Ameri Black, White, Specify: Whi	etc.
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12. thin 7	P M	npie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wo DO NOT us	rx done d se retired;	u <i>ri</i> n <i>g m</i> osi	t of workir	ng _	Depa	rtment	of Defense
LZ w be ygien	트립	S		1		Forei	gn Mi	lita	_			U.S.	Navy	
Maryland d 2 should be file th and Mental Hy	even even	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		,	
Mer Mer	narke	To	John Raymond Neder 19a. Informant's Name/Relationship (T)			101 11 11		10	111		Lucill			
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altimore, mit. Pages 1 an partment of Heal	:: If item 2 r or other		Ruby A. Neder / W 20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	'	2900 '. ace of Dispo metery, cren	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Loca	D 20712 ation - City or T	own, State
ITIN artme	ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Ft.	Linco	1n Ce	emete	ry (06/23	3/2008	Bren	twood,	MD
Dep a	any pope		Your Montagene	11 4	()	3/1	01 R1	200	chir	Ft.	Lincol	n Fun	eral Ho d, MD 2	ome, Inc.
100			23a. Part1. Epter the disease, or compl shock, or heart failure. List only o	ications that caused	d the death.								d FID 2	Approximate Interval Between
Exa	physician and street transit and	dicai Examiner	Sequentially list conditions, and a sequentially list conditions, and a sequentially list conditions, and a sequential list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	a consequi	ence of):								
death certific	by the attending plached for use as t	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pr					23	d. Date of deliv Month	ery Day Year
S the	been signed t	by P	Part II. Other significant conditions col			lting in the ur		-	n in Part I.					he cause of death?
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_ ×	this o	2	1 142 5 7 140			R/Outpatien			443 1401	rsing Hon	ne 5 🗌 Resid	dence 6	Other (Specia	(y)
	After	ation:	27. Manner of Death 1 Natural 2 Accident 5 Pending investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	at ? es 2 □ N		8d. Describe ł	now injury	occurred	
- 5 B	al Director: ad in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	jury - At hon c. (Specify)	ne, farm, stre	eet, factory	, office		2	8f. Location (5 City or Tox		Number or Run	al Route Number,
he Hospital in 24 hours a	4 4	edical (29a. Certifier 1⊠ Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis o and manner st	it exa <i>m</i> inatio	rledge, death on and/or inv	occurred restigation,	at the time in my op	e, date and inion, deat	d place, a	nd due to the od at the time,	cause(s) ar date and p	nd manner as s lace, and due t	stated. o the cause(s)
To the	10 to 1	Ž	29b. Signature and title of certifier	•	_		29c	. License	number			29d. Date	signed (Month,	Day, Year)
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Į	Physic	ian	1. Decedent's Name (First, Middle, Las	Catter					Month Day Year				3. Time o		
	/Medi	cal	Virginia	COII				of Dooth	June	<u> </u>	6, 2008 7:37 P.			Р. м	
	ogé Exami.	ner	4a. Facility Name (If not institution, give street and number) 7755 Southern Maryland Blvd.			4b. City, Town, or Location of Death Owings					Calvert				
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last b	irthday)	If Under 1 Yea	r If Under	24 Hrs.	8. Date of B	irth				or Foreign
п	Director		212-64-0762	□M 2[X F	93	Yrs.	Months Days	s Hours	Min.	8. Date of B (Month, D Dec.	29,1	914	Mar	lace (State try) y Land	
	pur »		Usual Residence of Decedent 10a. State 10b. County	1.	10c. City, Tov	un or Loc	ation							0d. Inside (Situ I insite
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	the N 28a-f notifie	rect	10e. Street and Number			OWIII	10f. Zip Code			<u> </u>	10a Ci	tizen of W	hat Coun		
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	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. W	/as Decedent of Yes, specify Cu		gin? (Spe	cify Yes or N	0-	14. Race	- Americ	an Indian,	
9	after or Ite mine	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No)		Yes, specify Cu ☐ Yes 2 1 No		n, Puerto	Rican, etc.)			, White,		
215-0036	ural",	d by	3 X Widowed 4 □ Divorced	Year or Dates:			Λ						whi		
15	"nati	lete	15. Decedent's Edi (Specify only highest grad	ucation de completed)	168	a. Decede Give k	ent's Usual Occi ind of work don O NOT use retir	upation e during mos	t of workii	ng	16b. K	(ind of Bu	siness/Ind	lustry	
212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			homemaker						OW	n ho	me	
d 2		Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, M				e, Maider	faiden Surname)			
lan		To B	Irving Hutchins Catterton					Alice Kathryn				Wilkerson			
Maryland		-	19a. Informant's Name/Relationship (T		1				nber or Rural Route Number, City or Town, State, Zip Code)						
	and and and and and and and and and and		Anne N. Brady, D	aughter			Brisco			·					
ore	permit. Pages 1 Department of H Important: If Iter any Injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	1		ition (Name of atory or other pi			ate	1	ocation - (•		
Baltimore,			4☐Donation 5☐Other (Specify) Smithville					e Cemetery 06/21/08 Dunkirk, MD Name and Address of Facility Rausch Funeral Home, P.A.							
Bal			21. Signature of Funeral Service Licens William R	Clon		1	325 Mt.						•		
STORES	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. A Part A Par								etween				
	The law requires that the death certificate be executed and the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of the control of th	consequence	of):	cerdent	- Let	R+ H	emipa	ires	12		2 w	eeks
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	ng Phys ter this neral dir	TOE	examiner? 1 ☐ Yes 2 📉 No	2 🗆 ER/O	ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						1)				
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isio	ttend death. stor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	OSe Place of injun	M 1 Yes 2 No										
Division	lor A after d Direc	Certification:	4 Homicide determined	(Specify)						Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Co	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Examone)	sician: To the best of iner: On the basis of eand manner state	xamination at	e, death nd/or inve	occurred at the estigation, in my	time, date an	id place, a th occurr	and due to the	e cause(s	s) and mai	nner as st	ated. the cause	(s)
	o the	Mec	29b. Signature and title of certifier	and manner state			29c. Licer	nse number			29d. Da	ate signed	(Month, i	Day, Year)	
	► S F Ö		_	Sterner	M.D.	•		D 1724	5			ne 18			
			30. Name and address of person who co	ompleted cause of dear	th (Item 23a)	(Type, P	rint)								

State Registrar 31. Date filed (Month, Day, Year)

Lew

DHMH 17 Rev 1/2001

Gerald P. Sterner, MD, 19 Cheaspeake Beach Rd., East, Owings, MD 20736

32. Registra Signature

JUN 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 § ay Bert A.G. Overby 5:50 A M 2008 4c. County of Death $P \cdot G$. 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hyattsville St. Thomas Moore Nursing Home 9. Birthplace (State or Foreign Country) $D_{\bullet}C_{\bullet}$ 8. Date of Birth (Month, Day, Year) 4 – 30 – 1 9 3 9 If Under 1 Year | if Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min 578-50-8061 1 XM 2 ☐ F 69 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Washington 1 ☐ Yes 2 X No D.C. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20011 U.S.A. 1415 Tuckerman St. N.W. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 No 1956 – if Yes, Give Year or Dates: 1958 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Overby Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1415 Tuckerson St. Nw Wash, D.C. 20011 Nancy Overby (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 6-25-2003 Wash. D.C. Rock Creek Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St. N.W. Wash. D.C.20011 21. Signature of Funeral Service Licensee Francy un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final ARTERIOSCLENATIC CAR DIOVASCULA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetai death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Onknown copha (o palhy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Salkal und other Deubits 1 ☐ Yes 2 No 1□ Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a

filed within 72 hours after death v Hygiene.

es 1 and 2 should be filed w of Health and Mental Hygie f Item 27 Is marked other ti

Pages 1 permit. Pages 1
Department of It
Important; If Ite
any Injury or ot

death certificate be executed

P.O. Box 68760,

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Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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completely To the within 2

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Physician/Medical

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Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes 2☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case refered to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide 4 Homicide

Hospital: 5 ☐ Pending investigation

6 Could not be

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ∏Yes 2 ∏No

26. Place of Death Check onl one

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier h herbrehne 29c. License number D01852 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DEVONE MD 4203 Weensbury 12d Hyatts ville MD20751 AI

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

JUN 2 4 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21963 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year John Person 15:39 PM 08 /Medical 06 6 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. Sex M ⊿ M 2 ☐ F 9. Birthplace (State or Foreign Country)
New York, NY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 105-56-7639 NY 8-18-1969 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD. P.G. Landover 1 □Yes Z □No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with "natural", or items 23a or 1806 Palmer Park RD. 20785 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 à 1 ☐ Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ne any hijury or other traumatic event, it is Marked once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Labor Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Person Gloria Fergurson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo Lee Person (Father) 1806 Pamer Park RD. Landover MD.20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Wall Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem, 1 Cem. 6-21-2008 Landover MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral 20011 908 Kennedy St. N.W. Wash. D.C. nuncis unt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardio pulmonay **Physician** resulting in death) -/Medical Due to (or as a consequence of): Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of The law requires that the death certificate be executed HY De ending physician and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) rthis certificate has been signed by the raid director, page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Hospital: Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) 06/20/08 D-52706 eted gause of death (Item 23a) (Type, Print) 30. Name and address of person Battimore Ave, Hyattsville MD 2078 WorktolaMD 5804 Askenati

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 0 8 21964 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Day **Physician** 5:15PM COLEY PADGETT JUNE 18 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The first set of Birth (Month, Dey, Year)

The first set of Birth (Month, Dey, Year)

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The first set of Birth (Month, Dey, Year) BETHESDA HEALTH & REHABILITATION CNT. MONTGOMERY Birthplace (Stete or Foreign Country)
_____ 5 Social Security Number 6 Sex **Funeral** 1 M 2□ F Director S.C. 245 16 6313 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 XYes 2 No Director MD. MONTGOMERY BETHESDA 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 5721 GROSVENOR LANE 20814 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CHEF PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FELIX PADGETT JENNIE MATHIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) WOODROW RAINSFORD/COUSIN 609 4th PL., S.W. WASHINGTON, D.C. 20024 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE PK. CREMATORY 6/24/08 RIVERDALE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility WATSON F. H. Af Funeral Service Licensee 3435 14th ST., N.W. WASH. D.C. 20010 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on even line. Approximate Intervel Between Onset and Death **Physician** . Atheroscelerotic Cardiovascular disease Immediate Ceuse (Final disease or condition resulting in death) /Medical unknown Examiner Due to (or as a consequence of) Examiner ettending physician end for use es the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? to Thrive, Cerebrovascular accident 24e. Wes an autopsy skinson disean 2/12/00 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To After this 27. Menne of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending spital or Attending hours efter death. neral Director: Afti y filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital within 24 hours e To the Funeral () completely filled 29a. Certifier 🖆 Certifying Physiclen: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and manner es steted. Medical 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted. (Check only one) 29d. Date signed (Month, Dey, Year) Chowdley, my NURUL CHOWDHURY, MD; 15216 DINO DRIVE; BURTONSVILLE, MD 20866 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
JUN 2 4 2008

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June **Physician** 2.00°8 0046 M Virginia N. Pounds /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Arundel Anne Arundel Medical Center Annapolis Anne If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days June 9 Y97926 Months Hours Maryland 1 □ M 2 □X 82 217-24-1296 Director Usual Residence of Decedent Maryland Anne Arundel 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 No Annapolis 10f. Zip Code 10g. Citizen of What Country? e o USA 21403 1350 Forest Dr. 'natural", or items 23a dical Examiner must b Funeral death 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical Center 0 Dietitian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd Mental Pages 1 and 2 should be Mammie Fisher Ith and Ment 27 is marked traumatic e Nobel Watkins ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Department of Health an Important: if Item 27 is any injury or other trau Valeria Johnson(Niece) 1350 Forest Dr. Annapolis, Md. 21403 Date 20c. Location - City or Town, State 20b Place of Disposition (Name of Canality, cantalory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Park 6-19-08 Memorial Annapolis, Md. 4 □ Donation 5 □ Other (Specify) Wanname Readless of Eaci Gons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 a M00483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Sepsis

Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Pnuemonia

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal Disease. as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Vascular Disease 24a. Was an autopsy performed? Yes 2 No has page certificate 1□ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) Injury 5 Pending investigation M 1 Tyes 2 No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0 Hospital 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date of the cause of t Medical 29a. Certifier completely (Check only one) and manner stated.

To the I within 2

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, C Year 0 2008

29b. Signature and title of certifier

30. Name and address of person who completed

Registrar's Signature

Ause of death (Item 23a) (Type, Print)

mp

29c. License number

058510

Stephen Olexo

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 7:10 P 1. Decedent's Name (First, Middle, Last) June 18, 2008 **Physician** W. Parker Loren /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Thomas More Nursing & Rehab. Center Hyattsville Prince George's 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) 9. Birthplace (State or Foreign Country) Ohio If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 277-14-9284 85 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4901 Cleveland Court 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Kalyes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 N Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Watchmaker/ Jeweler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Palmer Parker Grace Harlan Ε. ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2...
Department of Health ar
Important: if item 27 is
any injury or other trau 4901 Cleveland Ct., Temple Hills, MD 20748 Betsy Duvall / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 6/23/2008 | Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fytheral Service Licen 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Se uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed physician and s the burial-transit Monic Box 68760, Physician/Medical oticemu attending for use as 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 2 Fetal death Month 4☐Pregnant at time of death 5 Other (specify) ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certificate Yes To the Hospital or Attending Physician: within 24 hours after death. director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2XXXX0 4XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 the Funeral Director; After the mpletely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29c License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MASH, NGTON, VARUM 31. Date filed (Month, Day, Year) State JUN 2 3 2008 Registrar

DHMH 17 Rev 1/2001

			State of Maryland	-	irtment of H tificate of I		nentai Hyg R	leg. No. 20	08 21967		
	Dhorita	A	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th	3. Time of Death		
	Physici /Medic	cal	CHRISTOPHER A. PATTON J					22 21	008 3:02 A ^M		
	Examin		4a. Facility Name (If not institution, give street and number) 18004 ROCKY RIDGE LANE	4b. City, Town, or	Location of Death			4c. County of Death MONTGOMERY			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country)		
	Director	ctor	294 72 1525 125M 2 F 43	Yrs.			Feb.16,	1965	Ohio		
	yland now at		10a. State 10b. County 10c. City, T		cation	_			10d. Inside City Limits		
	e Mar 3a-f sh tiffied		Md. Montgomery 01	ney					1 □ Yes 2 MNo		
	with th	Dire	100.04 Panku Pidan Lang		10f. Zip Code 20832		1	Og. Citizen of W			
	ms 23	Funeral Director	18004 Rocky Ridge Lane 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-		- American Indian,		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Tes, specily Cuba	Specify:	nicall, etc.)	Specify:	white, etc. White		
50	"natu "natu edical	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Ki						Kind of Business/Industry		
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<u>p</u>	al Hyg d other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			a)		
ryla	d Menid to marked	P	Gerald A. Patton 19a. Informant's Name/Relationship (Type. Print)	10h Mailin	g Address (Street	Norma		ams	State Zin Code)		
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ()/		Rocky R				20832		
nore,			1 Burial 2 □ Cremation 3 □ Removal from State	netery, ciren	sition (Name of natory or other place Cemeter	:e) ;	Date 5/08	20c. Location - C	City or Town, State		
Baltimore, Maryland	permit. P Departme Importani any Injury		21. Signature of Funeral Service Licensee	22	. Name and Addre	ss of Facility Mt	uriel H.	Barber	Funeral Home		
	0.0 = 0.0		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.			038, Lay1			20882 Approximate Interval Between		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Metastatic C Due to (or as a consequent)	colore		ncer			Onset and Death Months		
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):							
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68760,	icate be executed physician and s the burial-transit	edical	d								
_	ertifica ling ph		IF FEMALE: 220 If you gutto me of programs					001 5.11			
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Euhours after of additionable this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	Month 4 Pregnant at time of death 5 Other (specify)							
		Medical Certification: To Be Completed by Ph	Tath. Other significant contributing to detail but not receiving states given at a						bute to the cause of death?		
ord							1 U Y	es 2 No	3 Probably 4 Unknown		
l Rec							24a. Was a autop perfor	sy p med? d	Vere autopsy findings available nor to completion of cause of leath? ☐ Yes 2☐ No		
VII:			25. Was case referred to medical examiner?								
0			27. Manner of Death 28a. Date of Injury 28	8b. Time of Injury	1 JUDON	4 Li Nursing H	ng Home 5				
Division or Vital Records,			2 Accident investigation		M 1 🗆	Yes 2 □ No					
			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)						'Street and Number or Rural Route Number, wn, State)		
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
			29b. Signature and title of certifier		29c. Licens		i		(Month, Day, Year)		
)			I Chihi Jayme	D 424		_	ne 23, 2008				
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D. 18111 Prince Philip Drive, #327, Olney, Md. 20832								
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 4 2008 32. Jegistrar's Signatur	i Ag	all						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 26 2008 Melvin Eugene Parrish June 12:40AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert. 11740 Asbury Circle, Apt. 1218 Solamans If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months XXM 2□F 90 May 4, 1918 Maryland 184-09-4717 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 2XXNo Director Maryland Calvert Solamans 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number an "natural", or items 23a or Medical Examiner must be r 20688 United States 11740 Asbury Circle, Apt. 1218 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 □ No If Yes, Give 1942 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White <u>م</u> Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) than the Passenger Conductor Railmad nd 2 should be filed value and Mental Hygie 27 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t and 2 should by Health and Menta tem 27 is marked Harry W. Parrish Elva Mae Alban 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frankie June Parrish / Wife 11740 Asbury Circle, Apt. 1218, Solomons, MD 20688 if item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 1 Burial 2 □ Cremation 3 □ Removal from State Important: i any injury o Middletown Cem. Freeland, MD 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St. New Freedom, PA 17349 ku 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SEVENE Wort Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification:

/Medical Examiner be executed sician and burial-tran physician the burial

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1

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P.O.

Division or Vital Records,

After Hospitai or Attending death. Director: after

To the Hosp...
within 24 hours after to the Funeral Dire

Medical

State Registrar

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 🗷 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

0064353 -

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40900 Merchants Lane, Suite 207, Leonardtown, MD 20650 Karen Tucker, MD,

2. Registrar's Signature

Registrar

State

32. Registrar's Signature

		F		State	of Maryland / D	ера	rtment of H	lealth :	and I	Mental	Hyg	iene		
	•	1 - For State Registrar			(Cer	tificate of L	Death			R	leg. No. 2	008	2197
N.E.	10	1. Decedent's Nam	e (First, Middi					2. Date			Vees	3. Time of Death		
nysicia Medica		WAI	TER,	ANDREW	STEPH	STEPHENSON			JUNE 29,2008		Year 8	12:55P		
kamine		4a. Facility Name (/		n, give street and no		4b. City, Town, or Location of Death TAL FREDERICK					th 4c. County of Death FREDERICK			
neral ector	1 1 mg da 1 1 1 1 1 M								24 Hrs. Min.			Col	9. Birthplace (State or Fore Country)	
		Usual Residence of	Decedent											
fled at	ctor	10a. State Maryland	10b. County	rederick	10c. City, Town	or Loc	Freder					10d. Inside City Limit		
pe no	Dire	10e. Street and Nu	mber			10f. Zip Code				10g. Citizen of What Country			•	
nust	era		114 E. South St. Marital Status 12. Was Decedent Ever in U.S.					21701 3. Was Decedent of Hispanic Origin? (Specify Yes or No-				14. Race - American Indian.		
	=	Marital Status		IZ. Was De	13. Was Decedent of Thispanic Origin: (Opecity 163 of 140									

114 E. South St. 11. Marital Status 1 ☐ Never Married 2 Married

12. Was Decedent Ever in U.S. Armed Forces? Armed Follows:
1 X Yes 2 No
If Yes, Give
Year or Dates 958-64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🗷 No

14. Race - American Indian, Black, White, etc.

White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+) 12

(Give kind of work done during most of working life. DO NOT use retired) carnival operator

16b. Kind of Business/Industry amusement

17. Father's Name (First, Middle, Last)

3 Widowed 4 Divorced

18. Mother's Name (First, Middle, Maiden Surname) Margaret Mary Grady

Walter Andrew Stephenson Sr. 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Doris L. Stephenson/wife

114 E. South St. 20b. Place of Disposition (Name of cemetery, crematory or other place)

16a. Decedent's Usual Occupation

Frederick, MD 21701-5618 20c. Location - City or Town, State

20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Mt. Olivet Cemetery 7/2/2008

Frederick, MD

21. Signature of Funeral Service Live

4 □ Donation 5 □ Other (Specify)

22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 23a. Part1. Enter the disease, or complications that decided the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

21762 Approximate Interval Between Onset and Death

Physician /Medical Examiner

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Department or Important: If I any Injury or Injury or

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Certification: To

Medical

filed within 72 hours after death with

Saltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

a.	precimonia
	Due to (or as a consequence of):
h	
D	Due to (or as a consequence of):

Due to (or as a consequence of)

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death

4☐Pregnant at time of death 9 Unknown

3 □Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No

24a. Was an autopsy perform

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No 1 Yes 27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day Year)

1 Inpatient

2 ☐ ER/Outpatient 3 DOA 28b Time of 28c. Injury at Work? 1 ∏Yes 2 ∏No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Frederick, MD 21701

29a, Certifier (Check only one) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number 200 65443 29d. Date signed (Month, Day, Year)

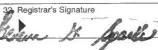
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Elena larikova 31. Date filed (Month, Day, Year)

400 W. Seventh St.

State Registrar



ORIGINAL

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04713 State of Maryland / Department of Health and Mental Hygiene John Hubert Singer 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0000 hrs Medical Examiner John Hubert Singer June 18, 2008 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 6407 Falkirk Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex Foreign Country Maryland **Funeral** Hours Months Days Director 1 X M 05/16/1933 214-30-598 2 Usual Residence of Deceden 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No N/ABaltimore MD hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21239 6407 Falkirk Rd. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 Marned Specify: White 1951-62 Yes 2 X No specify: If Yes, Give Year 3 XWidowed Divorced ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) it. Pages 1 and 2 should be filed within 72 l rtment of Health and Mental Hygiene, ortant: If item 27 is marked other than ", y or other traumatic event, the Medical E Baltimore, MD 21215-0036 Communications 3 Engineer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Paul Singer Helen B. Sakers Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Audrey Misal / Sister 2507 Kevin Lane Bowie, MD 20715 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery. Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 6/23/2008 Lorraine Park Cem. 4 Donation 5 Other Specify: 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses Crawn p 20715 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato arrest, shock, or he **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Intraoral Gunshot Wound Immediate Cause (Final disease **⊂**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and Physician/Medical UNPENDED **AMENDED** signed by the attending physician the detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 ✓ Yes 2 No 26.Place of Death (Check only one 25. Was case referred to medica Be examiner? Other; Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification Subject shot self FOUND: 1 Natural Yes 2 V No Pending Director: I in by the f Jun 18, 2008 1957 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 6407 Falkirk Road, Baltimore, MD determined (Specify) Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie June 19, 2008 icht O.C.M.E. C 30. Name and address of person who completed cause of death (Item 23a)

Registrar
DHMH 17 Rev 1/2001

OCME 2006

State

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

Patricia Aronica-Pollak MD.

JUN 2 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 18, 2008 **Physician** 4:25 R. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Lanham Prince George's 6902 Nashville Road 8. Date of Birth Month, Day, June 22, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 1 M 2 □ F 530-07-9207 86 Nevada Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 XXIIIo Director Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6902 Nashville Road 20706 USA Funeral within 72 hours after death Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No 1942— If Yes, Give 10/16 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 TX No Specify 1946 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) marked other than Elementary/Secondary (0-12) Electronic Engineer NASA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be finand Mental H Be Anna Helena Kummer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health a item 27 is Sheril Simas / Wife 6902 Nashville Rd., Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1 Department of H Important: If ite Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 6/23/2008 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deal Immediate Cause (Final Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the asn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 20 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2**XX**No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 2XXNo 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XX latural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident al or Attend s after death filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30 Name and address of derson who completed cause of death (Item 23a) (Type, Print) Wingson N 31. Date filed (Month, Day, Year

DHMH 17 Rev 1/2001

State

Registrar

JUN 2 3 2008

1 - For State Registrar

Director

Funeral

Be Completed by

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Physician

/Medical

Examiner

Funeral

Director

Physician

Please	e Type or Print in B	lack Ind	lelible Ink.	Ensure A	II Copies	Are Le	gible.		
For State Registrar	State of Maryland		rtment of H		Mental Hy	giene Reg. No.?	000	21071	
Decedent's Name (First, Middle, I	_ast)				2. Date of De		u u o	3. Time of Death	
FRANK EDWARD SES	SA				JUNE 1	7, 200	8 Year	9:30 P M	
4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town, or	Location of Death)	4c. Cou	unty of Death		
KRIS LEIGH ASSIS	TED LIVING		SEVERN	A PARK		ANN	E ARUN	DEL	
5. Social Security Number 6 098-16-5477	. Sex 7. Age (In yrs. la 1 ■ M 2 □ F 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da AUGUST	th ay, Year) 27,192	9. Birthp Cour NEV	place (State or Foreign htry) YORK	
Usual Residence of Decedent									
10a. State 10b. County	10c. City,	Town or Loc	ation				1	0d. Inside City Limits	
MARYLAND ANNE	ARUNDEL		SEVERNA	PARK				1 ☐ Yes 2 No	
10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?	
831 RITCHIE HIGH	WAY. #402		2	21146		UNIT	ED STA	TES	
11. Marital Status	12. Was Decedent Ever in U.S	3. 13. W	Vas Decedent of H	ispanic Origin? (S	pecify Yes or No	0- 14.	Race - Americ	an Indian,	
1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No WORI	ת.	Yes, specify Cuba	an, Mexican, Puerti	o Rican, etc.)		Black, White,	etc.	
3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WAR		☐ Yes 2 X No	Specify:		Sp	ecify: WHI	TE	
15. Decedent's (Specify only highest		(Give I	ent's Usual Occup kind of work done of OO NOT use retired	during most of wor	king	16b. Kind o	of Business/In	dustry	
Elementary/Secondary (0-12)	College (1-4or 5+) 4	INSURANCE SALESPERSON					INSURANCE		
17. Father's Name (First, Middle, La	est)			18. Mother's Nam	ne (First, Middle	e, Maiden Sur	rname)		
JERRY SESSA				MARY ME	ESSOROCO	A			
19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing	g Address (Street	and Number or Ru	ıral Route Nu m t	per, Cify or To	own, State, Zip	Code)	
JANE MARIE SEXAU	ER/DAUGHTER	603	SABER LAI	E, ARNOL	D, MARY	LAND 2	21012		
20a. Method of Disposition 1	Removal from State CROW	ace of Disposemetery, crem NSVILL TERY	sition (<i>Nam</i> e of natory or other plac E VETERA	NS JUNE	Date 27,2008		ion - City or To	own, State MARYLAND	
21. Signature of Funeral Service Li	Dikit	22. CRI	Name and Addre	ss of Facility FEI	LOWS B	ELFENI P.A.	BEIN &		
23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused the death	wsde	er the mode of dyir	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	death 3	Ectopic pregnancy	/			. Date of deliv	Day Year	
Part II. Other significant condition	s contributing to death but not resu	Iting in the un	derlying cause giv	en in Part I.		tobacco use Ķes 2 □ N		he cause of death? bably 4 Unknown	
	0				24a. Was	s an 2	24b. Were auto	opsy findings available	

Examiner

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

dical	•	d									
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 No 23c. If yes, outcome pt pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month									
	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part	t i.	23e. Did tobacco use contribute to the cause of death? 150 es 2 No 3 Probably 4 Unknown							
Completed				24a. Was an autopsy autopsy performed? 1 ☐ Yes 2 ☐ No							
Be (25. Was case referred to medical	26. Plac	Check only one)								
To E	examiner? 1 ☐ Yes ♣☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N	Nursing Home	e 5 ☐ Residence 6 MOther (Specify)							
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		d. Describe how injury occurred								
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical C		ysician: To the best of my knowledge, death occurred at the time, date a niner: On the basis of examination and/or investigation, in my opinion, do and manner stated.									
Me	29b. Signature and title of dertifier	29c. License number	6	29d. Date signed (Month, Day, Year)							

VICTOR PLANNER, M.D.

510

State Registrar

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15 31. Date filed (Month, Day, Year)

JUN 2 0 2008

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32 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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within 24 hours after death.

To the Funeral Director: A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Mamta S. Shah 2008 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Owings MILLS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day Year | Tan . 30) 23 Willington Court Owings Mills Baltimore County 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Year) 1 □ M 2 🛛 F India Director 219-51-7337 41 1967 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County 1 ☐ Yes 2X No Owings Mills 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23 Willington Court 21117 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Asian Hindu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Remesh D. Shaw ည Vidya R. Mahajan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sunil N. Shah - husband 23 Willington Court Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 22, Carroll Cremation Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (*Disease* or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🔣 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, certificate l After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the Hospital

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exact has must be notified at

Baltimore, Maryland 21215-0036

6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number D0059325 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1650 Orleans St #145, Baltimore MD 21231 Stearns Mo. Vered

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 4

32. Regiarar's Signature

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and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 200 Pear Month Snowden GiO A **Physician** Fmma une 211 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 11000 35/011 Westmins 3010 ent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 🖾 F 94 214**-1**8-7748 Sept_21, Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director New Windsor MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21776 United States 1318 Dennings Rd. by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3√Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If item 27 is marked other than 'Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Mt. Airy Pants Factory unknown Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Magers Evelyn Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dale Logue (Grandson) 1318 Dennings Rd. New Windsor, MD 21776 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 □ Donation 5 □ Other (Specify) 6/24/2008 Mt. Airy, MD Pine Grove Cem. 22. Name and Address of Facility urrier-Queen Funeral Home and Crematory, P.A. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Between Onset and Death
Onset and Death Immediate Cause (Final disease or condition resulting in death) Minutes Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 21 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has al director, page 2 (Yes al or Attending Physician: safter death.

I Director: After this certificated in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 2 No 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☐ Natural 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier me 21,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AnelMO 31. Date filed (Month, Day, Year) State JUN 2 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Day 35 A M **Physician** 2008 auna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 400 OUAIL RUN DRIVE CENTREVILLE OUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Months 1**X**M 2□F 64 213-42-6490 WASHINGTON, D.C. JUNE 26,1943 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MARYLAND QUEEN ANNE'S CENTREVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 400 QUAIL RUN DRIVE 21617 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or item Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Date 1:964–1972 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛣 No 3altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed r than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry COLLEGE College (1-4or 5+) Elementary/Secondary (0-12) **PROFESSOR EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental MAURICE LARUE SCOTT DORIS VIRGINIA SCHEITLIN ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERIDAN A. SCOTT/WIFE 400 QUAIL RUN DRIVE, CENTREVILLE, MARYLAND 21617 20b. Place of Disposition (Name of cemetery crematory or other place WOODLAWN MEMORIAL PARK 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Important: If any Injury or once, JUNE 26,2008 EASTON, MARYLAND 4 Donation 5 DOther (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Opset and Death 23a. Part1. Enter the disca shock, or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** mon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 TYes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ ★Q 24a. Was an autopsy performed? Yes 2 No certificate 1☐ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Medical Certification: To 1 T Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 5 Sesidence 6 □Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 Matural 1 ☐ Yes 2 🗌 No 2 ☐ Accident after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated hin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

Registrar

State

900

egistrar's Signature

Rd Sute 300 Ampoli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

JUN 24

3
Physician
/Medical
Examiner
Funeral

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Ma	aryland /	-	rtment of H		Mental F	lygien Reg. N	0000	21978
Physicia /Medic		 Decedent's Name (First, Middle, La Peggy R. Scherer 	,					2. Date of Month		year Year 2008	3. Time of Death
Examin	-	4a. Facility Name (If not institution, giv Atlantic General	re street and number) Hospital			4b. City, Town, or Berlin			4	c. County of Death Worcest	ter
Funeral Director		5. Social Security Number 6. S 578-24-8842 Usual Residence of Decedent	THE OWNER	e (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month,	Birth Day, Yea /192		pplace (State or Foreign intry) nican Rep.
Maryland a-f show ffied at	tor	10a. State 10b. County FL Monroe		10c. City, Tov							10d. Inside City Limits 1 ☐ Yes 2√ No
ath with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 27358 Jamaica Lai	T			10f. Zip Code 33042				USA	
urs after de al", or items xaminer n	by Fune	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces? 1 Yes 2 IV			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 💢 No	ispanic Ongin? (in, Mexican, Pue Specify:	Specify Yes or erto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh	
permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I flem Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	i+)	(Give I life. D	ent's Usual Occup kind of work done o O NOT use retired	ation during most of w	orking	16b.	Kind of Business/I	
d be filed wantal Hygier ed other the cevent, the	Be	12 17. Father's Name (<i>First, Middle, Last</i> Charles E. Rupke)			поше	maker	18. Mother's Na		dle, Maide	Own H	ome
alth and Me 27 is mark traumation	٩	19a. Informant's Name/Relationship (Frank Scherer, Sr	(Type. Print)				and Number or I	Rural Route Nu		or Town, State, Z	
Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		cemet	tery, cirem t Me	sition (Name of natory or other place morial Pe	ark 6/1		Ber		
permit. Depart Import any Inj once.		21. Signature of Euneral Service Lice	// 5		1	Name and Addres	am St	Berlin	. MD	eral Home 21811	Approximate
Physician /Medical	Í	23a Part1. Enter the disease, or conshook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	_aAcut	the death. Do	ardi	al infar	ction	ac or respirator	y arrest,		Interval Between Onset and Death
Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence							
icate be executed physician and the bunal-transit	edical Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence	e of):						
ath certif attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)			_	23d. Date of deli Month	very Day Year
w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions	contributing to death bu	ut not resulting	in the un	derlying cause giv	en in Part I.				the cause of death?
The law rec ate has beer page 2 shou	Completed							24a. V	utopsy erformed?	prior to c death?	topsy findings available completion of cause of
hysician this certifi al director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🔀 Inpatie			t 3□ DOA Oth	4 □ Nursing	Home 5□F	lesidence	6 □Other (Spec	ify)
Ilng After fune	Certification:	27. Manner of Death 1 XNatural 2 Accident 3 Suicide 4 Homicide	e 290 Place of init	y Year) ury - At home,	. Time of Injury farm, stre		y at k? Yes 2 □ No	28f. Locatio		jury occurred and Number or Ru	ral Route Number,
	Medical Cert	29a. Certifier 1 🔀 Certifying Pl	hysician: To the best of miner: On the basis of and manner sta	of my knowledo				ce, and due to	the cause	(s) and manner as	
To the within 2	Mec	29b. Signature and title of certifier	nond N			29c. Licens				Date signed (Month /16/2008	ı, Day, Year)
3A G		30. Name and address of person who J. Van Egmond Mi	completed cause of do	eath (Item 23a) ealthwa	y Dr	., Berli	n, MD 2	1811			
Stat Registra	_	31. Date filed (Month, Day, Year) JUN 2 4 20	32. Begistra	ar's Signature	So	uli					

		•	State Registrar	State of Maryland / De	partment of Heal ertificate of Dea	ath	Reg.	2000	2 9 / 9
	Physici	an	Decedent's Name (First, Middle, Last)			2.	Month	Day Year	5:30am M
	/Medic	al		Sours	4b. City, Town, or Local	ition of Death	June 19	4c. County of Death] 3:30aiii
	Examin	er	4a. Facility Name (If not institution, give str Futurecare Nursing		Clinton	and of Doute		Prince Geo	rge's
***	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthd	(av) If Under 1 Year If U	nder 24 Hrs. 8. burs Min.	Date of Birth (Month, Day, Young . 2, 1		lace (State or Foreign
	Director		231-34-5748	^{M 2□ F} 76 Yrs	. Mondie Baye	A	ug. 2,1	931 Virg	inia
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			1	0d. Inside City Limits
	Maryla f sho	jo	Maryland Prince Geo	rge's Temple	Hills				1 □ Yes 2 □ No
	r 28a	irec	10e. Street and Number	280 5	10f. Zip Code		10g	. Citizen of What Cour	ntry?
	should be filed within 72 hours after death with the Maryland and Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show umatic event, in Medical Evalunce must be notified at	Funeral Director	6804 Dodge Lane		20748			U.S.A.	
	ems ems	ne.	11. Marital Status	. Was Decedent Ever in U.S. 1	Was Decedent of Hispani If Yes, specify Cuban, Me	nic Origin? (Specii exican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
36	s afte	ž.	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1√Pyes 2□No Korean 1√Yes, Give Year or Dates: Vietnam	1 ☐ Yes 2 ☐ No Spe	ecify:		Specify: Whi	te
21215-0036	hour tural	Completed by	15. Decedent's Educa	tion 16a. De	ecedent's Usual Occupation		16	b. Kind of Business/Inc	dustry
215	nin 72 3. In "ng Medik	plet	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) (G liii College (1-4or 5+)	ive kind of work done during e. DO NOT use retired)			0 1 D	1.
21	d with	S E	12th		Police Offic	Cer Mother's Name (/	Circa Adiabata Ada	Capitol Po	olice
Maryland	be file Ital Hy d oth event	Be	17. Father's Name (First, Middle, Last)		18. 7	Ruth	Doffle		
Z ≥	ould d Mer narke natic	٩	Clark Sours 19a. Informant's Name/Relationship (Type	Print) 19h M	ailing Address (Street and N				o Code)
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylam Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show mimportant: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important or other traumatic event, I'm Modreal Evan Inc. Trust be notified at once.	-	20a. Method of Disposition	20b. Place of Di	sposition (Name of crematory or other place)	Dat	e 20	c. Location - City or To	own, State
E O	Pages 'nent of hant: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Red 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Lee Cren		June 2	.0,	Clinton, Ma	aryland
Baltimore,	permit. Departm Importa any Inju		21. Signatur une une Licensee	MANIELSE	22. Name and Address of	Facility I		ral Home,	
<u> </u>	8 9 E 8 9		JALY THE	MUITOT	6633 Old_Al				
			23a. Prit1. Enter the disease, or complications, or heart failure. List only one	cause on each line.					Approximate Interval Between Onset and Death
- Side	Physician	П	Immediate Cause (Final disease or condition resulting in death)	Cancer of the o	colon w/metas	tasis to	the li	ver	
-	/Medical Examiner		1	Due to (or as a consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					30.0	
oʻ	e exe ian at urial-t	EX	resulting in death) Last	Due to (or as a consequence of):					
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d.						
	certifi oding p	/Me	IF FEMALE: 23	c. If yes, outcome of pregnancy	_			23d. Date of deliv	/ery
Вох	that the death certifed by the attending detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
P. O.	ding Physician: The law requires that the de n. After this certificate has been signed by the funeral director, page 2 should be detached	hysi	9 🗆 Unknown	9 Unknown					
	s that gned I	oy P	Part II. Other significant conditions cont		ne underlying cause given in	Part I.		acco use contribute to t	
g	requires een sign rould be	bed	Hepatic Encephol	opathy			1 Li Yes	2 No 3 Pro	
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E H	. The cate h						1 □Yes 2	□to 1 □ Yes	2 🗆 No
V:	Physician: this certific ral director, I	Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	Other	Place of Death		nce 6 Other (Spec	
Division of Vital Records,	Phys er this eral di	15.	1 ☐ Yes 2 ☐ No	28a. Date of Injury 28b. Tin	ne of 28c. Injury at	4646		v injury occurred	
On	Attending r death. Sector: After by the fune	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)		2 🗆 No			
Visi	Atter	iffica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28	If. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
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	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	ical	(Check only 2 Medical Examin	ician: To the best of my knowledge, er: On the basis of examination and/	death occurred at the time, o or investigation, in my opinio	date and place, a on, death occurre	nd due to the ca d at the time, da	use(s) and manner as te and place, and due	to the cause(s)
	thin 2 the 1	Medical	29b. Signature and title of certifier	and manner stated.	29c. License nur	mber	29	d. Date signed (Month	, Day, Year)
	5.≱5.8	-	D Brown		D 515 8	20		June 20,	2008
			30. Name and address of person who	leted cause of death (Item 23a) (T	/pe, Print)			·	
J.	B 124	*	Babram Pishdad, M	.D. 1328 Souther	n Anenue SE S	Suite 31	0 Washi	ngton DC 20	JU32
Ĭ		ate	31. Date filed (Month, Day, Year) 3 2	32. Refistrar's Signature	South .				
	Regist	rar	0011 2 0 2	The state of	March				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Clarence Edward Shaw /Medical 2008 June 9:25 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-Frostburg Nursing & Rehab Center Frostburg Allegany 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours 220-26-9635 Director 78 JUNE 9,1930 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits MD Examiner must be notified ALLEGANY Director FLINTSTONE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 12810 DRY RIDGE ROAD , or Items 23a filed within 72 hours after death v Hygiene. Funeral 21530 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: KOREA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced Specify: "natural", WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MARYLAND STATE ENGINEER & SURVEYOR i. Pages 1 and 2 should be filed w thent of Health and Mental Hygier tant: If item 27 is marked other it ilury or other traumatic event, the HIGHWAY ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD SHAW LEONA MAE HUFFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHEL FRANCES SHAW / WIFE 12810 DRY RIDGE ROAD, FLINTSTONE, MD 21530 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 DxBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 Donation 5 Dother (Specify) MT. HERMAN CEMETERY 06/25/2008 CUMBERLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERTAND, Part1. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. lediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ta disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (3) as a consequence on To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9□Unknown 9 Unknown as been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 24a. Was an autopsy performed? Yes 2 10 No this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Donursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only

within 24 hours a To the Funeral D

67

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUN 2 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wonsock Shin, M.D., 48 Tarn Terrace, Frostburg, MD 32. Registrar's Signature

29c. License number

D0055325

29d. Date signed (Month, Day, Year)

June 22,2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Пау Vear Month **Physician** Michelle Schaidt Gay 08 1905 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany WMHS-Braddock Campus Cumberland If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months 1 ☐ M 2 🂢 F 46 Director 217-76-0792 01/16/1962 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f sh notified 1 X Yes 2 No MD Cumberland Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o e USA "natural", or items 23a 6 West Second Street, Apt 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) <u> Hair Stylist</u> Beauty 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thorpe Walters Carole Edwin Allen Kav ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 337 Dorn Avenue, Cumberland, MD 21502 E. Allen Thorpe / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/25/2008 Cumberland Cremtory Cumberland, MD 21. Signature of Funeral Service Incense 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or consequ disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Alcohalism for use as the burial-tran P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes — 2 ☐ No 9 ☐ Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, þ Encephalopa 1 Yes 2 No 3 Probably 4 Inknown Completed Encepha 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 은 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Division or After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death unerai Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Emmanu + Osai - Baamah 500 Men 500 Memorial AVE. Cumberland, NOD 21502 ^{Year)} 2008 31. Date filed (Month, State Registrar

		4	State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 21982
			Registrar 2. Date of Death 3. Time of Death
	Physicia	an	CARLTON E CEMBOWER. 6 24 2008 10.35PM
	/Medic Examin		a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			Leasant VIEW NWS-us Howe MTA: MD 2-177 Cantle Scale of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) Output 9. Birthplace (State or Foreign Country)
	Funeral Director		214-28-4619 Security Number 9. Sex Months Days Hours Min. 04/30/1917 Maryland
	0	- H	Sual Residence of Decedent 10d. Inside City Limits 10d. Inside C
	faryla shov ed at		1 □Yes 2½ No
	r 28a-	Director	MD Garrett Mountain Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	th with	a D	416 Shenandoah Ave. 21550 USA 416 Shenandoah Ave. 13 Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian,
	hours after death with the Maryland tura!", or ttems 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status 12. Was Deterent Even II o.s. Armed Forces? If Yes, specify Cuban, Mexican, Puèrto Rican, etc.) Black, White, etc.
36	rs afte	by F	1 ⊠ Never Married 2 ☐ Married 1 ⊠ Yes 2 ☐ No 1 ☐ Yes 2 ☒ No Specify: Specify: 'Specify: 'White
Ş	72 hou ratura ical E		15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
21	ne. han "i	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Farming
0 5	ould be filed within 72 hours after death with the Marylan Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show artc event, the Medical Examiner must be notified at	ပ္တို	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
an	should be marked o matic eve	To Be	Edward S. Sembower Myrtle B. Holden
Maryland 21215-0036	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 and 2 Health tem 27	-	Thomas E. Doyle/ Lawyer 131 N Third Street, Oakland, Maryland 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State
altimore,	of of		1⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other place) Pleasant Valley Cem. 06/28 / 2008 Oakland, Maryland
ati.	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Live 1988 22. Name and Address of Facility Stewart Funeral Home
Ö	permir Depar Impor any Ir		32 South Second St., Oakland, Maryland 21550
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arross, Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or followsequence of):
	Examiner		Casives cothin sclendis
		ner	b. Due to (or as a consequence of): (Se Desay of the Conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury) (Se Desay of the Conditions)
	icate be executed physician and s the burlal-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
8760,	be ex	dical E	
9	tificate ng phy as the	fedic	
Вох	requires that the death certific een signed by the attending p hould be detached for use as:	Physician/Me	1F FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 23c. If yes, outcome pf pregnancy 1
	he dea the at thed fo	ysici	In the past 12 months? 1 Yes 2 Pregnant at time of death 5 Other (specify)
. P.O	uires that the de signed by the a d be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute the cause of death?
rds	w requires been sign should be	ed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute the cause of death? 1 Yes 2 No 3 Probably 4 Tunknown
Records,	aw as b 2 sl	Completed	24a. Was an autopsy prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death?
<u>=</u>	ate pag		1 Yes 2 No 1 Yes 2 No
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes No
0	g Physer this leral di	I-	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Sec. Injury at Work? 28d. Describe how injury occurred Work?
ion	Attending r death. ector: After by the fune	atio	2 Accident investigation M 1 Yes 2 No
Division	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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	To tha Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifiler (Check only one) Check only one) Certifying Physician of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the Complex complex	Ž	29b. Signature and title of certifler 29c. License number 29d. Date signed (Mghth, Day, Year)
		6	30. Name and address of person who completed gause of death (Item 23a) (Type, Print)
		NA	Melvindae hardon has assorbed the sold through the sold t
	St Regis	ate trar	31. Date filed (Month, Day, Year) JUN 2 7 2008 32. Figistrar's Signature

		1	For State Registrar		Sta	ate of Ma	arylan	d / Depa <i>Cei</i>	artment of F rtificate of I	ieaith and D <i>eath</i>	Mental Hy	ygiene Reg. No.	2008	219	83
			1. Decedent's Nam	e (First, Middle	, Last)			-			2. Date of D Month	eath Day	y Year	3. Time of De	ath
	Physicia /Medic	_	Helen	I. Smi	i'h						June	2	5. 2008	7:30	AM
4	Examin	_	4a. Facility Name (i	If not institution	, give street	and number)			4b. City, Town, or	Location of Dea	ith		County of Deat	n	
4			217 H	opewell		17.0-	- (1	and high days	Church If Under 1 Year	Wille If Under 24 Hrs	S. I R. Date of B		Harford	hnlace (State or F	oreian
	Funeral		5. Social Security N		6. Sex 1 ☐ M 2			ast birthday) Yrs.	Months Days	Hours Min	. (Month, E			hplace (State or F untry)	oroigir
	Director	-	217-96-1 Usual Residence of	2167 I			89				May 2	2, 19	19 Ma	tyland	
	yland yow		10a. State	10b. County				, Town or Lo						10d. Inside City I	
	Mar a-fsl	cto	MD	Har	ford		C	hwichv	ille					1 ☐ Yes 2	≥ No
	ith the Maryland or 28a-f show be notified at	Director	10e. Street and Nu	mber					10f. Zip Code			10g. Cit	izen of What Co	untry?	
	irs after death with	<u>a</u>	217 Ho	pewell	Road				21028				I.S.A.		
	tems	Funeral	11. Marital Status		l Ar	as Decedent med Forces?		S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes of Norto Rican, etc.)	10-	 Race - Ame Black, White 		
36	s afte	by F	1 Never Marr 3 Widowed		If '	∐Yes 2 🛣 I Yes, Give ear or Dates:	NO		1 □Yes 2 No	Specify:			Specify:	hite	
Ş	72 hours after death with the Maryland "natural", or items 23a or 28a-f show raical Examinar must be notified at	ed	O ESTAGORICA	15. Deceden				16a. Dece	dent's Usual Occup	ation		16b. K	ind of Business/		
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pu	be filed within tal Hygiene. ed other than event, the Me	Be (17. Father's Name	(First, Middle,	Last)					18. Mother's Na	ame (First, Midd	le, Maiden	Surname)		
yla	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Manare.	ဂ္		m Bowli							<u>ie Webb</u>				
/ar	s 1 and 2 should if Health and Men tem 27 Is marke other traumatic		19a. Informant's N			*	. 1	1	ng Address (Street						
e)	1 and 2 Health a tem 27 I		Hecen 20a. Method of Dis	E. Brau	<u>in</u> (0	daughte			Langley		Date		ocation - City or		
Baltimore, Maryland 21215-0036	nt of I		1 🔀 Burial 2	Cremation		al from State			osition (Name of matory or other place		1001000	.,		M P	,
Ħ	it. Pa intme intant njury		4 ☐ Donation 21 Signature of Fi	5 Other (S			Har	<u> ford 1</u>	lem. Gard 2. Name and Addre	ens 6/	<u>30/2008</u> Zellman	Abe	rdeen,	<u>Masujiano</u> D	
Ba	permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other		Signature of P	uneral Service	Licensee	ollr	Y	I .	23 S. Wa	shinatar	Lewman Stroot	Ha	1500 do G	race. MD)
		1	23a Part 1. Enter	the disease, or	complication	s that cause	d the death		ter the mode of dyi					Approximate Interval Between	
	Physician		Immediate Cause	(Final	on, nech	use on each li	ne.	TICO	<u>e</u>					Onset and De	
	/Medical		disease or condition resulting in death)	on	a	Due to (or as	a cousequ	uence of):		,					
	Examiner						1-1-	en	fense	m				Jen	رب
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Ma	ecute ind transi	Examiner	Cause (Disease or that initiated event resulting in death)	.5	c										
68760,	Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	<u>E</u>	resulting in death)	Lust	l	Due to (or as	a conseq	uence on.							
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	eath certifi attending for use as	/Me	IF FEMALE: 23b. Was deceder	at prognant	23c. lf	yes, outcome	of pregna	ancy					23d. Date of de	livery	
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G.	res that signed I be det	by P	Part II. Other sign	ificant conditi	ons contribu	ting to death t	out not res	ulting in the t	underlying cause gi	ven in Part I.				o the cause of dea	
rds	w require been signated should b										- 1[☐Yes 2	2 □ No 3 □ P	robably 4 Un	iknown
BCO	e law re has be e 2 sho	Completed									_ 24a. W	topsy	→ prior to	utopsy findings av	/ailable use of
Œ	The ate h page	ĕ									pe 1 □ Yes	nformed2 s 2 DN	death? o 1 ☐ Ye:	s 2□No	
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n	tending Physician: The i eath. for: After this certificate h the funeral director, page	jon	27. Manner of Dea 1 Natural	5 Pendir	ng	3a. Date of Inj (Month, D	ury ay, Year)	28b. Time o Injury	Wo	iryat rk?]Yes 2 □ No	28d. Describ	e now inju	ary occurred		
isio	ttend death stor:	icat	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could		Re Place of In	iury - At he	ome farm st		Jies ZCINO	28f. Location	(Street a	and Number or F	ural Route Numb	er.
Division of Vital Records,	or A after of Direct	Certification: To	4 Homicide	detern	nined 2	building, e	tc. (Specif	fy)	reet, factory, office		City or	Town, Star	te)		
	spital lours neral		29a. Certifier	1 Certifyi	ng Physicia	n: To the best	t of my kno	owledge, dea	th occurred at the	ime, date and pl	ace, and due to t	he cause	(s) and manner a	as stated.	
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical	(Check only one)	2☐ Medical		On the basis and manners		ation and/or i	nvestigation, in my	opinion, death o	ccurred at the tin	ne, date ai	nd place, and du	e to the cause(s)	
	To the To the To the Comp	ž	29b. Signature an	d title of certifie	1	1 -	1		29c. Licen	se number		29d. D	ate signed (Mon	th, Day, Year)	
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	5		30. Name and add	dress of person	4 G	- Sone	16	701	Print) Cla	erles S	to fre	eto.	ond E	2. 20%	e1
	Sta Regist		31. Date filed (Mo	JUL 0 8	2008	32 Regist	rar's Signa	ature	marker	;					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 1 Bay Ardell Odessa Thomas 2008 6:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 940 Bay Forest Court Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 11 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Year) 1932 Days Months Min. 1 ☐ M 2 1 F Maryland 215-34-0568 75 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show a or 28a-f show t be notified at 10d. Inside City Limits Maryland Anne Arundel Director Annapolis 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a caminer must be 940 Bay Forest Court 21401 USA 2 should be filed within 72 hours after death n and Mental Hygiene.

Is marked other than "natural", or items 23: raumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: Black 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) 12th Licensed Practical Nurse General Hospital es 1 and 2 should be filed to the filed to the filed to the filem 27 is marked other in other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Benjamin Johnson Annie Ardell Clark ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise O. Hector(Daughter) 1505 Bay Ridge Ave Annapolis, Md. 21403 20a. Method of Disposition 20b FFIacq of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any Injury or ot 1 XBurial 2 □ Cremation 3 □ Removal from State Memorial Gardens 6-19-08 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) WM ame Read of & cil Sons Mortnary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. M02483 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed as the burial-transi and Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2D No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknowh The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ has been si ge 2 should 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or

Registrar

31. Date filed (Month, Day, Year) JUN 2 0 2008

plame and address of person

d title of certifier

one) 29b. Signature

29d. Date signed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician JOHN Thomas 18, 2008 6:50AM M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hoapice Baltimore, Md. Baltimore | Months | Days | Hours | Min. | May 5 , 1 960 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 578-84-5629 48 Wash., D.C. **№** M 2 🗆 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinar must be notified at any injury or other traumatic event, the Modical Examinar must be notified at any injury or other traumatic event, the Modical Examinar must be notified at any injury or other traumatic event. 10b. County Funeral Director Md. P.G. Lanham No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6807 Forbes Blvd. 20706 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 21215-0036 Specify:Black 1 ☐ Yes 2 No Specify Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th College (1-4or 5+) Laborer Construction Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Thomas Barbara Ε. Howard ပ္ 19a. Informant's Name/Relationship *(Type. Print)* Linda Wright – Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6807 Forbes Blvd. Lanham Md. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Resurrection June25,08 Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 20001 21. Signature of Funeral Service Licensee Robinson Funeral Home 1313 6th St. NWWash, 23a. Part* Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): vate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | Uhrknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, page 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1405pice 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

(2)

State Registrar FVANCS X. STVAIN
31. Date filed (Month, Day, Year)
JUN 2 3 2008
32. Regis

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 ST PAUL BALT MD Z1202

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Jackie Andrew Taylor 12:30 P M May 7, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1 X M 2 □ F Days Hours APR 15, Director 47 1961 Maryland 216-78-2505 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show er than "naturel", or items 23a or 28a-f show the Wedical Exeminar must be notified at 1 XYes 2 No Director Maryland | Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1120 Oxford Circle 21740 United States Funeral death Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Disabled None of Health and Mental Hygid fitem 27 is marked other r other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Burliss Donald Taylor Rebecca Ann Belcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Elliott / Cousin 12205 Bayswater Rd., Gaithersburg, MD 20878 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Department of F Important: If itel any Injury or ott once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Park 05/13/2008 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thibadeau Mortuary Service, 21. Signature of Funeral Service Licensee M00956 933 Gist Avenue, LL, Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) FEW DAYS CARDIORESIRATORY FAILURE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events HEPATIC ENCEPHALOPATHY FEW DAYS Due to (or as a consequence of). Examine been signed by the attending physician and should be detached for use as the burial-transit certificate be execute HEPATO-RENAL FAILURE FEW WEEKS resulting in death) Last Due to (or as a consequence of): Physician/Medical EVERAL YEARS CIRRHOSIS OF LIVER Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CHRONIC ALCOHOLISM Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, page 1 ☐ Yes 2 X No 1 □Yes 2 💢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35497 JUNE 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANVIR A. PASHA, M.D., 1122 OPAL COURT, HAGERSTOWN, MD 21740 31. Date filed (Month, Day, Year) Registrar's Signature State 23 NUL 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

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Phys		1 - State Registrar 1. Decedent's Name (First, Middle, Last)			rtificate of		2. Date of De	Reg. No.		3. Time of Death	
	ician dical	CHERYL ELIZABETH VE	NEZIANI				JUNE	20 20	Year 2008	2:30 P	
	niner	4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, o	r Location of Death	1	4c. County	of Death		
.# ·	- 1	202 HOLLY COURT				VENSVILLE		QUEEN ANNE'S			
Funera		5. Social Security Number 6. Sex	200	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birl (Month, Da			ace (State or Forei	
Directo	or	Usual Residence of Decedent	5	3			AUGUST	10, 1954	LL.	LINOIS	
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e Mar a-f sl	ctor	MARYLAND QUEEN AN	INE'S		STEVEN	SVILLE				1 □ Yes 2 🗙 N	
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	y?	
ath w	<u>a</u>	202 HOLLY CO			216			UNITED STATES			
within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		pecify Yes or No o Rican, etc.)	fy Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE			
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State Registrar 31. Date filed (Month, Day, Year)

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÷.	Physici	an	Georgia K. V								Date of De Month		, 2008	3. Time	of Death
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au	be be	o Be	John H. Bur								Boone	, ivialuell	Surname)		
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	Physician		Immediate Cause (Final disease or condition	A	pirate	in pre	unoù	9						Onset and	Death
	/Medical Examiner		resulting in death)	Due to	(or as a con	sequence of):	,							- C - C	3
	Lxammer	_	Sequentially list conditions,	b. Ad	af ,	sequence of): Les piva to soquence of):	a dis	The	· Ly.	rdo	~			on de	~
	sit sit	nine	Sequentially list conditions, if a y, leading to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a con	suquence of):									O
,	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a con	sequence of):									
09/90	e be e sician buria	la E			(
00	ficate g phys	edical		d											
X D D	n cert	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou									23d. Date of d	elivery	
Ď	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Preg	birth 2□f nant at time		Ectopic pre Other (s <i>p</i> e						Month	Day	Year
5	tr the by the rache	Physician/M	9 ☐ Unknown	9□Unkr	nown										
ָה ה	as the gned se dei	by P	Part II. Other significant condition	ons contributing to c	leath but not	resulting in the ur	nderlying cau	use give	n in Part I.		23e. Did to	obacco u	se contribute	to the cause of	death?
ecords,	equir en si ould b		Dematin								1 🗆 🗅	Yes 2[□No 3□F	robably 4	Unknown
ວັ	law r as be	ple									24a. Was		24b. Were a	utopsy findings	available
	The aate h	Completed									autop perfo 1□ Yes	rmed? 2 K No	death?		cause or
אומ	cian: ertific	Be (25. Was case referred to medical examiner?							of Death	(Check only o	,			11
5	Physi this o	۵,	1 ☐ Yes 2 🔀 No			2 ☐ ER/Outpatien			4 LI Nur	sing Hon	ne 5 🗆 Resid	dence 6	6 □Other (Sp	ecify)	
	ing F	ino in	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Yea	r) 28b. Time of Injury		c. Injury Work		1	8d. Describe h	now injur	y occurred		
2	ttenc death stor: the	cat	2 Accident investig 3 Suicide 6 Could r	ot be	of inium.	t home form str	M		es 2□N						
2	after after Direction by	Certification:	4 ☐ Homicide determi	ned build	ing, etc. (Sp.	it home, farm, stre ecify)	eet, lactory,	onice		2	City or Tou	street and vn, State,	d Number or F }	Rural Route Nui	nber,
	spital ours neral		29a. Certifier 15∕2 Certifyin	g Physician: To the	e best of mv	knowledge, death	occurred at	the time	e date and	Inlane a	and due to the	oaneo(e)	and manner	o stated	
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours affect death. Within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director.	Medical	(Check only 2 Medical one)	Examiner: On the b	asis of exam ner stated.	nination and/or in	vestigation, i	n my op	inion, deat	h occurre	ed at the time,	date and	place, and du	is stated. ie to the cause((s)
	To th To th comp	Me	29b. Signature and title of certifier				29c. l	License	number			29d. Date	e signed (Mor	th, Day, Year)	
			Rositan)	wan f	M.D			1)	4344	6			6.18.0	8	
	(4)	1	30. Name and address of person	who completed caus	se of death (I	ltem 23a) (Type, I	Print)						*		
			ROINT AND TOO	. ~ A a 1.	0 0	DA. G.	/	5	Suit	7- 22	c 1		1 - 1-	2 1	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 3 2008

32. Registrar's Signature

amend item 12 per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 06/20/08 dlw State of Manyland / Department of Health and Mental Hygien 2008 State of Maryland / Department of Health and Mental Hygien? 0 8 1 - For State Registra Certificate of Death edent's Name (First, Middle, Last 2 Date of Death 3. Time of Death Physician BERG RIGHT WILLIAM 005 2 M 2008 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Y Aug 30 6. Sex 9. Birthplace (State or Foreign **Funeral** Year Days Months Hours Min 10XM 2□ F 220-16-7373 Yrs 80 Ĩ927 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r then "natural", or iteme 23a or 28a-f ebow the Medical Exercises must be notified at Maryland Anne Arundel Annapolis 1X Yes 2 ☐ No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1790 B Belle Dr. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2. No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. a filed within 72 hours after d I Hygiene other then "natural", or item Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: 1950-52 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12th 0 Cook Bowie State College other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked othin any lighty or other traumatic event ARRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barney Wright Anne Harris ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Washington(Daughter) 468 Worthington Rd. Millersville, Md. 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-20-08 Crownsville, Md. Maryland Veteran Mame Reacted of Colleging Ons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapplis, Md. 21401 Deen m0048 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicism and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has 2□ No Division of Vital 1 ☐ Yes 2 100 1 Tyes Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death 1 ☐ Yes 2 ☐ No efter death Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide in 24 hours.
the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I within 2. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who FENSE 31. Date filed (Month, Day, Year) . Registrar's Signature State JUN 2 0 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a per dr., g884, 10/28/08dbb Reg. NO. 1 - For State Registrar Reg. No 2008 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month **Physician** HELEN RUTH WATKINS 3008 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Havre de Gra Harford Memorial Nosoita Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day) **Funeral** Hours 1 □ M 2**X** F Days Min. 112-44-3227 56 DEC 21, 1951 Director NORTH CAROLINA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1

Yes 2 □ No Director MARYLAND HARFORD ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 384 OXFORD AVENUE 21001 Health and Mental Hygiene. sem 27 Is marked other than "natural", or items 23a other traumatic event, the Medical Examinatins! USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No IfYes, Give Year or Dates: 1972–75 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: Completed by BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US ARMY 12 CLERK TYPIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAKE BAINES MAGGIE BARNES ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. RONALD WATKINS / HUSBAND 384 OXFORD AVENUE, ABERDEEN, MARYLAND 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST VET. 4 ☐ Donation 5 ☐ Other (Specify) 6/24/08 OWINGS MILLS, MARYLAND 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, 21. Signature of Funeral Service Licensee Scott Coleman MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** unknown aray Resperatory /Medical Due to (or as a conseque ce of):

Ischemic Heart Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Myocardial Infact cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Yo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 5 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Magner of Death 28c. Injury at Work? 28d. Describe how injury occurred

e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certific letely filled in by the funeral director,

lam Vineunto Physician: Wathins, Nelen

VD

Certification:

1 Natural 2 Accident 3 Suicide

4 ☐ Homicide

29a, Certifier

5 Pending investigation 6 □ Could not be

1% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature) and title of certifie

1 ☐ Yes 2 ☐ No

29c. License number PR-016329. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cabrera, M.D., Va Maryland Health Care System, Perry Point, MO 21902 31. Date filed (Month, Day, Year)

State Registrar

Medical

JUN 1 8 2008

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4+IVA

To the Hosp within 24 hou To the Funer completely fil

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) \mathbf{A}^{M} 2008 2:35 JUNE 21 **Physician** NATALIE MAY WALTERS 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 22,1927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number VIRGINIA **Funeral** 1 □ M 2 🕱 F 81 230-30-8250 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Mydical Event and two motified at QUEEN ANNE'S CHESTER Director MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21619 307 OLD POINT ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examinat once. 1 Never Married 2 Married Specify: WHITE 1 □ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BESSIE MAY WILLIAM HUMMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 307 OLD POINT ROAD, CHESTER, MARYLAND 21619 CHESTER J. WALTERS 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date CHESAPEAKE CREMATION JUNE 24, 2008
CENTER 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State STEVENSVILLE, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 is the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death Par I. En Er the discuse, or complications shock, or heart failure. List only one cau Immediate Cause (Final disease or condition Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d, Date of delivery 23c. If yes, outcome of pregnancy Day 23b. Was decedent pregnant in the past 12 months? Year 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐ 9 Unknown 9 Unknown has been signed by e 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 Probably 4 Unknown ð 1 ☐ Yes 2 ☐ 1¶0 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🗆 No 1 Yes 1 ☐ Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Injury 5 | Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 Suicide 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hours a Hospital 29a. Certifier Medical (Check only one) completely and manner stated. the 29c. License number 29b. Signature and title of certific 37936 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) Drive Chipe M 2/11

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Ye ar MARY FRANCES WEBBER 6/18/2008 12:05P 4c. County of Death 4b. City, Town, or Location of Death

/Medical Examiner **Funeral** Director death with the Maryland 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it of Madical Experiment by rediffied in I and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 and Mental Hygiene. of Health permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.

Physician

Physician /Medical Examiner

burial-trar physician at the burial attending pl signed by the a this funeral After

death certificate be executed Box 68760, Records, ttending Physician: death.

P.0.

sion of Vital

Divi	To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by
	r3.
	Regi

4a. Facility Name (If not institution, give street and number)
HOSPICE OF QUEEN ANNE'S
HOSPICE CENTER CENTREVILLE OUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Hours Months Days 1 □ M 2 🖺 F MD 78 /13/1929 218-22-1760 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐Yes 2 X No Director MD ANNE ARUNDEL ODENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21113 1300 GILL STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2 [] If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 X No Specify Specify: à WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OPERATOR MAIL SERVICE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WINFIELD SCOTT MORGAN ANNA MAY KEITHER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1300 GILL STREET, ODENTON, MARYLAND 21113 GAIL SMITH/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition JUNE 24 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN CEMETERY GLEN BURNIE, MARYLAND 2008 22. Name and Address of Facility 21. Signature FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 106 SHAMROCK RD. CHESTER, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart fai lications that caus the death. one cause on each in a Do na enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOUSE 2No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and nanner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie use of death (Item 23a) (Type Print) Name and address of person who completed tate 0 2008

trar

Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

		. For	Type or Prin State of Ma		Оера	rtment of H	lealth and			_egible.		
	_	- State Registrar			Cer	tificate of L	Death	2. Date of Dea	Reg. No.	2008	3 2 9 9 3	
Physicia /Medic		1. Decedent's Name (First, Middle, Las Gerald C. Wes						JUNE	19 Day	2008	20:13 M	
Examin	er	4a. Facility Name (If not institution, give Peninsula Region		1 Cente		4b. City, Town, or	Location of Deal	th	4c.	County of Deat	nico	
Funeral			al Medica PX MM 2□ F 7. Age	e (In yrs. last bir	8. Date of Birl (Month, Da	th y, Year)						
Director		Usual Residence of Decedent	9. Birt PA Co									
yland		10a. State 10b. County		10c. City, Tow	n or Loc	ation			-		10d. Inside City Limits	
Ba-f sl	ector	MD Worcest	er	0cean	Cit	-		1	10 - Citi-	en of What Co	YYes 2 No	
a or 2	Funeral Director	10e. Street and Number 15 Wicomico stre	eet			10f. Zip Code 21842				JSA	ountry:	
ems 2	nera	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. W	L Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Specify Yes or No rto Rican, etc.)	- 1	4. Race - Ame Black, White		
If it is within 72 hours after death with the Maryland Hygiene. Hygiene, them "natural" or Items 23a or 28a-f show ant, the Medical Examiner must be rutified.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	If Yes Give			o 1 □ Yes 2XXNo <i>Specify</i> : wh				Specify: white		
72 hour	eted	15. Decedent's Ed	ucation	16a	. Deced	ent's Usual Occup	ation	orkina	16b. Kir	nd of Business/	Industry	
vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) b		kind of work done of NOT use retired ender	1)	9	res	tauran	t	
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should be and Mental s marked o	To B	Otha West			-			eth Hass				
C (0 100 G		19a. Informant's Name/Relationship (Robert West-brot				g Address (Street Glen Arn				70wn, State, 2 21057	Zip Code)	
s 1 and 3 of Health item 27		20a. Method of Disposition				sition (Name of eatory or other place		Date	20c. Lo	cation - City or		
Pages 1 tment of H tant: If iten		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	y)	Cape	Hene	elope	6/2	3/2008		nkford,		
permit. Departr Imports any Inji		21. Signature of Funeral Service Licer	Chlod		108	Name and Addre William	is stree	urbage Fi	unera	18Home		
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do	not ente	er the mode of dyir	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ac.	a consequence		cardi	al Ir	Harc	ROV	1		
Examiner		Sequentially list conditions	Care	-mar	7	Argen	y Di	sease	<u>د</u>			
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
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nding I	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			3				23d. Date of de	elivery	
e death	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No	1	2 ☐ Fetal death t time of death		Ectopic pregnand Other (specify) _	:y			Month	Day Year	
that the		9 ☐ Unknown Part II. Other significant conditions of	ontributing to death b	ut not resulting i	in the un	iderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute t	o the cause of death?	
quires en sign uld be	d pa	Diabetes						10	Yes 2	□No 3□P	robably 4 Unknown	
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n: The flicate I fr, page		25. Was case referred to medical	•	,			00 Pi 4 P	1 □ Yes	ormed? 2 No	death? 1 ☐ Ye		
yslcia yslcia is certi directo	To Be	examiner? 1 Yes 2 MNo	Hospital: 1 Inpatio	ent 2 ☐ ER/O	outpatien	t 3 DOA Oth	er.	eath (Check only Home 5 Res		6 ☐ Other (Spe	ecify)	
ding Physician: The law n. After this certificate has funeral director, page 2 %	on: J	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of Injury	Wor		28d. Describe	how injur	y occurred		
Attend death ctor: /	ficat	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of Inj	ury - At home, fa	arm, stre	M 1 ==	lYes 2 □ No				Rural Route Number,	
tal or /	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)				City or To	wn, State			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best miner: On the basis of and manner st	of examination a	and/or inv	vestigation, in my	opinion, death oc	curred at the time	, date and	place, and du	as stated. le to the cause(s)	
To the within To the comple	Me	29b. Signature and title o certifier	11			29c. Licens	se number		29d. Da	te signed (Mon	nth, Day, Year)	
		Mu				03	4768		6	1201	06	
BA3+1		30. Name and address of person who	completed cause of c	leath (Item 23a)	(Type, I	rint)	SAlish	iny md	21	801		
Sta		31. Date filed (Month, Day, Year)	32. Pegisti	rar's Signature	1	29c. Licens D 3 Print) NOLL St.				-		
Registr	ar	JUN 2 4 20	JUO JOSE	20 10	M							

			For State Registrar	State of Mar		artment of H		nd Mental F	lygien Reg. N	211119	21994			
			Decedent's Name (First, Middle, La	st)				2. Date of	Death	eath 3. Time of Death				
	Physici /Medic		VIRGINIA E. W	ARD		7				5 une 21, 2008 2200 PM				
Ì	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o		Death	4	c. County of Death				
			SALISBURY REHAB		G CENTER			MD. 2180		WICOM:				
	Funeral Director		5. Social Security Number 6. S 214-03-0981	Sex 7. Age (□M 2XC F	(In yrs. last birthday,	Months Days	If Under 24 Hours	4 Hrs. 8. Date of (Month, 9/29/	Birth Day, Yea 1917	r) 9. Birthp Coun Mary	lace (State or Foreign itry) yland			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Limits			
	Aarylan f ehow	5	MD Wicomic		Salisbur	17					1 XYes 2 ☐ No			
	288-	rect	10e. Street and Number		Darrabur	10f. Zip Code			10g. C	itizen of What Coun	ntry?			
	3a or	Funeral Director	200 Civic Avenue			21804	ļ			USA				
	deati	nera	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origi	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Americ Black, White,				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "neturel", or Items 23a or 28a-f ehow any Injury or other treumatic event, the Medical Examinar must be notified at ODEs.	þ	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 24 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒No	Specity:			Specify: wh:				
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<u>2</u>	ithin nan	g	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)			al 13 a				
12	tygier her ti		17. Father's Name (First, Middle, Last	1	Cleri	cal	18 Mother	's Name (First, Mid		Civil Serv	vice			
Maryland	ntal Hed of	Be	Stephen James Wai					ie Pruitt	,	.,,				
Ž	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (19b. Mail	ing Address (Street			mber, City	or Town, State, Zip	Code)			
S	ad 2 s		Carole Lynch (ne	• •		Woodland B								
ē,	S 1 at f Hea f Hea othe	1	20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other plac	ce)	Date	20c.	Location - City or To	own, State			
E	Page nent o nt: If iry or		1-1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		1			5/25/2008	Poo	comoke Cit	ty, MD			
Baltimore,	permit. DepartmImporta any Inju		21. Signature of Furteral Service Lice	nsee	H	2. Name and Addre	uneral	l Home, P	rofess	sional Assoc ty, MD 218	iation			
	_		23a. Part1. Enter the disease, or com	plications that caused the	ne death. Do not en	ter the mode of dyir	ng, such as c	ardiac or respirator	y arrest,	LY, MD ZIG	Approximate Interval Between			
-	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	1	//)	0	202		Onset and Death			
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	- Car		200			jean-			
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87	physicate physicate	dicai		_ d										
Box 6	certifica nding pl use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of delive	ery			
	death e atte	siclar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify) _	у		-	Month	Day Year			
P.0	at the	Phy	9 Unknown			4. 10.	in Dard I	220 [id tobacco	o use contribute to the	he cause of death?			
Division of Vital Records,	es pe	Completed by Physician/Me	Part II. Other significant conditions	contributing to death but	not resulting in the i	underlying cause gr	ven in Part i.				pably 4 Dunknown			
O O	> -0 75	plet						24a. V	utopsy	prior to co	ppsy findings available impletion of cause of			
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ita	ysicien: The is certificate director, pag	Be	25. Was case referred to medical examiner?					of Death (Check or	ily one)					
× ×	W 15	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient		nt 3LI DOA				6 ☐Other (Specif	5)			
E C		ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (Wo	ryat rk?]Yes 2.⊟N		pe now in	jury occurred				
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Ď	lor A efter Direct In by	Certification:	4 ☐ Homicide determined	building, etc.	y - At home, farm, s (Specify)			City or	Town, Sta	ate)				
	To the Hoepital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	edical C	(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of e	xamination and/or it									
	thin 2 the orthe	Med	one) 29b. Signature and title of certifier	and manner state	, u.	29c. Licens	se number		29d. [Date signed (Month,	Day, Year)			
	£ 3 £ 8		10/10	182/		0-	2-1	300	6	190	£0:			
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	, Print)	0 1 -	()	1	1				
B	A 3		WILLIAM ROBINS,				RY, MD	21804	1025					
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 4 2	32. Pegistrar	's Signature	berte								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #18, nls, per fd, 06/20/08, Allegany Co. State of Maryland / Department of Health and Mental Hygiene 2 0 08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month GARY WISEMAN /Medical 06 16 2008 1515 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JULY 17,1944 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6 Sex 9. Birthplace (State or Foreign 1**∑**M 2□ F 215-42-2587 63 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits iral", or items 23a or 28a-f shor Examiner must be notified at Director ALLEGANY 1 ☐ Yes 2 XNo CUMBERLAND 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? death with 13308 BEDFORD ROAD, N.E. 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 M Yes 2 □ No If Yes, Give Year or Dates: '62-'66 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2XNo 3 Widowed 4 Divorced Specify: "natural", WHITE Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ALLEGANY COUNTY than Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN BOARD OF EDUCATION other 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filk tment of Health and Mental H tant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be CARL VERNON WISEMAN LOUISE ELIZABETH WRKING WERKING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA WISEMAN / WIFE 13308 BEDFORD ROAD, N.E., CUMBERLAND, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages:
Department of IImportant: If ite
any Injury or ot
once. 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) M.S.V.C.-ROCKY GAP 06/19/2008 FLINTSTONE, MD 21. Signature of Funeral Service Licena 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 40chua 202 GREENE STREET, CUMBERLAND, MD 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pulmons Carclio **Physician** disease or condition resulting in death) /Medical Due to (or as consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and I-tra Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9□Unknown 9∏Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page ; autopsy performed certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 14+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 Abdul Cheema m. S 900 Selon DR. Cumberland nds 31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 2008 State Registrar

			for State Registrar	State of Maryla	•	artment of F <i>rtificate of</i>			iene _{eg. No} 2008	21996			
	D		1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	th Day Year	3. Time of Death			
	Physici Medio/		William	Watson	W1	horton		June	22 2008	0139 ^M			
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea				
eld'	_		Carroll Hospice 5. Social Security Number 6	Dove House	rs. last birthday)		minster If Under 24 Hrs.	8. Date of Birth	Carro	OLL rthplace (State or Foreign			
	uneral irector		213-24-6134	1MM 2□ F 78	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day)	, Year) C	ountry) ryland			
ס			Usual Residence of Decedent					02/01/	1750 110				
arylar	show	<u>_</u>	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
the M	28a-f	Director	MD Allega	iny	LTTI	ntstone 10f. Zip Code		1	Og Citizen of What C	Og. Citizen of What Country?			
th with	23a or	ral Dir		pin Road, NE			21530		USA				
G Z I Z 1 S-UUSO filed within 72 hours after death with the Maryland Hydione	reportants if the azi and worlden riggere. The potation of the azi is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at one.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	If Yes, Give Kor	ean	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🙀 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, White Specify:				
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bluor A	narke	ဥ	Robert 19a. Informant's Name/Relationship	Easter	-	orton (Street			r, City or Town, State,				
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star Hear	item		20a. Method of Disposition	20		osition (Name of matory or other place			20c. Location - City or				
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the death of	To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐ Ectopic pregnand ☐ Other (specify)	у		23d. Date of de Month	elivery Day Year			
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lan: 1	rtificar tor, pa	Φ	25. Was case referred to medical				26. Place of Death			s 2 No			
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F and and and and and and and and and and	After t funera		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	Wor		28d. Describe ho	ow injury occurred	House			
Attender death	ector: by the	ertification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of Injury . A	t home, farm, str		Yes 2 □No	28f. Location (St	reet and Number or F	Bural Route Number,			
pital or	eral Di	O		Physician: To the best of my			me date and place			as stated			
the Hos	the Fun	Medical		aminer: On the basis of examand manner stated.		vestigation, in my o	ppinion, death occurr	red at the time, d	ate and place, and du	e to the cause(s)			
		2	29b. Signafure and title of contifier	One	WD	29c Licens	00542	218 2	9d. Date signed (Mon 06-23	th, Day, Year)			
W W	UA IRS		30. Name and address of person when the second seco	o completed cause of death (I	tem 23a) (Type,	Print) Mala	alm olai	ve h	9d. Date signed (Mon 06-23.	Hu MD			
	Sta Registr		31. Date filed (Month, Day, Year)	37 Registrar's Sig	gnature do	rele				2113			
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			For State Registrar	Oldio of W	arylaria /	Cei	rtificate o	f Dea	th		Reg. No	2008	3 21	99		
	Physicia	an	1. Decedent's Name (First, Middle,				Mo				Date of Death Month Day Year					
	/Medic		Eva	Marguer			Whets		une 1		2008 c. County of Deal	1:26	Р М			
- 6	Examin	er	4a. Facility Name (If not institution, 11717 Coleman				4b. City, Town, or Location of Death Midlothian				40					
	Funeral				ge (In yrs. last	birthday)	If Under 1 Year Months Day	ar If Un	der 24 Hrs. 8.	Date of Bir	rth	Allega 9. Bir	hplace (State	or Foreign		
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	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside	City Limits		
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	the M 28a-f	rect	MD A1	legany		Mid	lothian 10f. Zip Code	,			10g. C	itizen of What Co		Λ		
	3a or	Funeral Director	11717 Coleman	Road			· ·		543			USA				
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of If Yes, specify C	f Hispanic	Origin? (Specif	y Yes or No) -	14. Race - Ame Black, Whit				
5	or Ite	y Fu	1 ☐ Never Married 2 🏋 Marrie	d 1 ☐ Yes 2 【】 If Yes, Give		1	1 □ Yes 2)(□ N			,		Specify:				
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2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationshi Charles E. Whet	1 21			ng Address <i>(Stre</i> 7 Colem					or Town, State, AMD 215	1			
נֿע	of Heal		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of matory or other p	lace)	Date	е	20c. l	ocation - City or	Town, State			
	Page nent a		1 ☐ Burial 2 【☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			erlan	d Crema	tory				mberland				
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700	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	ath 3[⊒Ectopic pregna ☑ Other (specify,					23d. Date of de Month	livery Day	Year		
į	the d	nysi	1 ∐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown												
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5	ath. r: Afte e fune	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	ay Year)	Injury		/ork? □Yes 2	2 □ No							
2	or Atte ter dea lirecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	I Zoe. Place of III	jury - At home tc. <i>(Specify)</i>	, farm, str	eet, factory, office	e	28	f. Location (City or To		and Number or R te)	ural Route No	ımber,		
ב	pital o		29a. Certifier 1X Certifying	Physician: To the best	of my knowle	dae deat	h occurred at the	time dat	e and place, an	d due to the	e cause(s) and manner a	s stated			
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	то th within то th	Me	29b. Signature and title of certifier				29c. Lice	nse numb			29d. D	ate signed (Mon				
	nds		•	1-30	Primary ((ma 1)	nysivas.	D00	63368			June 19	9, 200	5		
R	u DB		30. Name and address of person w Dong Lee, M		death (Item 23	rive.	Cumber	land	, MD 2	1502						
	Sta		31. Date filed (Month, Day, Year) JUN 1 9		rar's Signatu		parle									
	Registr	aı	3011 2 0	2000												

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Sue Warhaft Aretta 1640 2008 18, June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Cumberland 638 Washington Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 6. Sex Social Security Number **Funeral** Days Hours Months Min. 1 □ M 2 🕅 F 79 216-22-6392 11/29/1928 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show "natural", or Items 23a or 28a-f shovidical Examiner must be notified at 1 □XYes 2 □ No Cumberland MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 638 Washington Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Baltimore, Maryland 21215-0036 Specify: 2 3 Widowed 4 □ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic access. Elementary/Secondary (0-12) College (1-4or 5+) Drapery Co-Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Martha Cecil Swavne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Trolley Bridge Circle, Quakertown, PA 18951 Dana P. Baker / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory | 06/20/2008 | Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licens 404 Decatur Street, Cumberland, MD 21502 23a. Part1. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ONE YEAR a HYPERTENSIVE ATHEROSCIENOTIC CURENARY /Medical Due to (or as a consequence of): DISONSE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) June 19, 2008 cus D33417 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1068 National Highway, LaVale, MD James R. Moen, M.D., MIL 31. Date filed (Month, Day, Year) 19 2008 32 Registrar's Signature State Registrar

			For State	State of Maryla	•	artment of H tificate of L		•	200	8 21999
			Registrar 1. Decedent's Name (First, Middle, Last)		067	inicale of L	Jean -	2. Date of Dea		3. Time of Death
	Physicia		Dane JEI	FFREY	W	ilson		June	Day Year	L - IDM
1	/Medic Examin		4a. Facility Name (If not institution, give si	reet and number)			Location of Death		4c. County of Dea	3 7 7 7 3
	LAMIIII		The Johns Hopkins Ho			Baltimore		To Barrat Bird	Balt	Abolesa (Chata as Familia)
	Funeral Director		5. Social Security Number 6. Sex 220-69-0100	M 2 \square F	3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	, Year) 9. 5 6,2004Ma	rthplace (State or Foreign ountry) rvland
	73		Usual Residence of Decedent					1001	0,200 1114	
	nylan show at	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ra-f stiffed	Director	MD Allegan	y Cu	mberla					
	with the	Ö	10e. Street and Number 824 Bishop Wal	sh Rd		10f. Zip-Code 21502			10g. Citizen of What C United S	
	ms 2: must	Funeral		2. Was Decedent Ever in I	J.S. 13.	Was Decedent of H f Yes, specify Cuba		pecify Yes or No-		erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 □ Yes 2 🏋 No	n, Mexican, Puert Specify:	o Rican, etc.)	Black, Wh	ite, etc. ite
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Baltimore, Maryland 21215-0036	ntal Hyellil	Be	17. Father's Name (First, Middle, Last) Jeff Wilson					i Cuthb	, Maiden Surname) Derston	
چ	hould d Me mark matic	ြ	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street			er, City or Town, State,	Zip Code)
Σ	nd 2 s ulth an 27 is r trau		Jeff Wilson/Fat	her	824	Bishop	Walsh H	Rd,Cumb	erland, M	d 21502
re,	of Hear of Hear item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re		Place of Dispo	sition (Name of natory or other place	θ)	Date	20c. Location - City of	r Town, State
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			shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.		500				Onset and Death
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Ö.	e deat	Physician/M	1 Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			World	Day Tour
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mor	nth, Day, Year)
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		4	30. Name and address of person who co		em 23a) (Type,				-	_
-			Nicole Shilkofs	ki m.o.			600	North Wo	lfe St, Baltim	ore, MD, 21287
		te	31. Date filed (Month, Day, Year)	32. Registrar's Sigr	nature	analle 8				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		(Certificate of	Death	1	roman rij	Reg. No	.200	8	220	000
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/Me	dical	Alma Elizabeth			4h City Town		of Dooth	June				2145	M
Exar	niner	4a. Facility Name (If not institution, Memorial Hospit	-		4b. City, Town, Cumber		or Death		- 1	c. County of D			
Funer	al		6. Sex 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under		8. Date of Bi	rth	9.	Birthplac	ce (State or	Foreign
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and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						100	I. Inside Cit	v Limite
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r 28a	Director	10e. Street and Number	<u>_</u>	GLants	10f. Zip Code				10g. Ci	itizen of What	Country	/?	
death with the Maryland ms 23a or 28a-f show r must be notified at		891 Dorsey Hote	l Rd., Apt.	24	21536				US.	A			
er dea tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of If Yes, specify Cu	Hispanic Or oan, Mexica	rigin? (Spo	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V			
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Mal nd 2 sho lith and 27 is ma		Gary A. Werner/	, , , ,		000 Sloan A						e, zp c. 532	oue)	
Item other		20a. Method of Disposition			Disposition (Name of crematory or other pla			Date		ocation - City		n, State	
Page ment c ant: If		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spi			wn Mem. Ga		June	26, 2	800	LaVal	e, M	Maryla	nd
Daltillore, Maperalt. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra	once.	21. Signature of Functial Service Li	person)	22. Name and Addr	ess of Facili	ity Nev	wman Fu	nera	al Home	es, i		
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Atten death	fical	3 Suicide 6 Could no	t be 28e. Place of injur	y - At home, farm	n, street, factory, office	1163 2		28f. Location (Street a	nd Number or	Rural R	loute Numb	er.
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To th within To th	Me	29b. Signature and title of certifier	1		29c. Licen	se number			29d. Da	ate signed (Mo	onth, Da	y, Year)	
		Salsaher	-Nama!	Y	D	581	65.	5	June	24	2	800	
	11	30. Name and address of person wi	no completed cause of dea	ith (Item 23a) (Ty		^	, ,	-		1 1	1	11 1	
70	10	31. Date filed (Month, Day, Year)	VAWAD	's Signature	Y.U. 150	DX d	65	Ur	aNi	bvil	101	140	
Regis	itate strar	JUN 2 6	2008	a B	Angel 3							215	36